Public Pharmacy Benefit Manager Transparency Report - 2021 Data

08/01/2022

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Pharmacy Benefit Manager Transparency Reporting – 2021 Data

Minn. Stat. § 62W.06, subd. 2 requires all licensed pharmacy benefit managers to submit to the Department of Commerce a transparency report containing both aggregate and claims level data for business from the prior calendar year. Commerce is required to publish the public data contained in PBM transparency reporting to the agency on its website.

Reporting process

Commerce provided all licensed entities instructions and three templates for aggregate, claims level data, and public reporting.

PBMs were required to submit transparency reporting information to Commerce by June 1, 2022. Commerce requested that PBMs submit all three completed templates; however, due to the varying nature of PBM business models and contracts, a given PBM may not be responsible for submitting a full report. As such, PBMs were given the option to submit "zero" reports when applicable. PBMs claiming to be exempt from all reporting requirements were asked to submit written rationale for the basis of that claim.

A summary of the type of reports received by Commerce are shown in the table at right.

Summary of response from PBMs	
Total Licensed PBMs	42
Public Reports Submitted	15
Zero Reports Submitted	11
PBMs not responding to Commerce	5

The data published in the attached public reports is drawn from the aggregate report submitted by the each PBM, except data that would be considered trade secret under Minn. Stat. § 13.37. As required by law, the public reports do not contain any information such as claims level data that could lead to identification of a plan sponsor, and to further protect plan sponsor identity, the reports do not include the name of the PBMs submitting them.

Data limitations

- PBMs were given instructions regarding units, rounding, and calculated fields, but the Department cannot guarantee full compliance with the reporting instructions.
- The data in this report has not been independently audited.
- While the Department provided a data dictionary to each PBM, some PBMs may have relatively small variations in how they calculated amounts based on their own internal definitions of a given term.
- The public reports in this document are as submitted by the PBMs. Commerce has not vetted, modified, or reformatted any of the data.

Definitions of terms used in PBM public transparency report

WAC
The aggregate wholesale acquisition cost (WAC) of a given drug from the drug's manufacturer (does not include discounts or rebates).

Net WAC
WAC minus any rebates and other fees paid to the PBM with associated claims.

Non-Plan Sponsor

Refers to network pharmacies or pharmacies in which the PBM has a contractual relationship. For the purposes of the transparency report, data from non-plan sponsors excludes any fees assessed directly to plan sponsors (such as a per-member per month fee or any other quantifiable monetary restriction applicable only to the plan sponsor).

Rebates
Defined in Minn. Stat. § 62W.02 Subd. 17 as all price concessions paid by a drug manufacturer to a pharmacy benefit manager or plan sponsor, including discounts and other price concessions that are based on the actual or estimated utilization of a prescription drug. Rebates also include price concessions based on the effectiveness of a prescription drug as in a value-based or performance-based contract.

Other fees and payments
Any fees and payments, other than those defined as rebates, associated with the pharmaceutical claims in the given category from any source.

Total Rebates and Other Fees and Payments
Calculated as a sum of *total rebates* and *other fees and payments*

Total Rebates and Other Fees and Payments – Non Plan Sponsor
Total amount of rebates and other fees and payments except those that come directly from plan sponsors

Retained Rebates and Other Fees and Payments – Non Plan Sponsor
Total amount of rebates and other fees and payments except those directly from a plan sponsor that are retained by the PBM as revenue for services provided

Retained Rebates and Other Fees and Payments Percentage – Non Plan Sponsor
Calculated as a ratio of *retained rebates and other fees and payments* to *total rebates and other fees and payments*

Therapeutic Category
The grouping of drugs based on similar characteristics such as chemical structure, mechanism of action, or disease treated. PBMs were instructed use the US Pharmacopeia (USP) classification system and report drug groupings at the category level.

Plan Sponsor

A group purchaser as defined under Minn. Stat. § 62J.03; an employer in the case of an employee health benefit plan established or maintained by a single employer; or an employee organization in the case of a health plan established or maintained by an employee organization, an association, joint board trustees, a committee, or other similar group that establishes or maintains the health plan. This term includes a person or entity acting for a pharmacy benefit manager in a contractual or employment relationship in the performance of pharmacy benefit management. Plan sponsor does not include the Minnesota Department of Human Services.

Data for Publication on Commissioner Website

Masked PBM ID	7EB6NV
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments

Percentage Across All Plan Sponsors	**Highest**	**Lowest**	**Mean**
	0%	0%	0%

Totals During Data Period	**WAC**	**Rebates**	**Other Fees and Payments**	**Total Rebates and Other Fees and Payments**	**Total Rebates and Other Fees and Payments - Non Plan Sponsor**	**Retained Rebates and Other Fees and Payments - Non Plan Sponsor**	**Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor**	**Net WAC**
	$ 3,243,508	$ 678,585	$ -	$ 678,585	$ 678,585	$ -	$ -	$ 2,564,923

Top 10 Categories by Spend - Descending Order

Therapeutic Category	**WAC**	**net WAC**
Immunological Agents	$2,126,113	$1,830,736
Central Nervous System Agents	$280,268	$239,084
Blood Glucose Regulators	$219,837	$101,645
Antineoplastics	$111,114	$86,671
Respiratory Tract/Pulmonary Agents	$100,398	$49,629
Blood Products and Modifiers	$93,910	$68,243
Dermatological Agents	$66,873	$51,993
Genetic, Enzyme, or Protein Disorder: Replacement, Modifiers, Trea	$60,078	$49,865
Products Without a USP Category	$38,173	$12,787
Anticonvulsants	$27,794	$19,844

Data for Publication on Commissioner Website

Masked PBM ID	BKCNQN
Data Period	CY2021

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
0%	0%	0%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$68,619,000	$7,924,500	$0	$7,924,500	$0	$0	0%	$60,694,500

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
TARGETED IMMUNOMODULATORS	$13,674,000	$10,864,000
ANTIVIRALS	$11,566,000	$11,537,000
ANTIDIABETICS	$10,313,000	$8,021,000
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$4,537,000	$3,711,000
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$3,599,000	$3,584,000
ANTIPSYCHOTICS/ANTIMANIC AGENTS	$2,918,000	$2,895,000
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$2,738,000	$2,398,000
MULTIPLE SCLEROSIS AGENTS	$2,514,000	$2,343,000
ENDOCRINE AND METABOLIC AGENTS - MISC.	$2,489,000	$1,985,000
DERMATOLOGICALS	$2,339,000	$2,335,000

Data for Publication on Commissioner Website

Masked PBM ID	44N4ZW
Data Period	CY2021

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
97	5	24

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$462,176,000	$161,819,000	$22,073,000	$183,887,000	$183,887,000	$22,073,000	12.00%	$278,282,000

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
ANALGESICS - ANTI-INFLAMMATORY	$132,393,000	$85,276,000
ANTIDIABETICS	$90,619,000	$38,531,000
DERMATOLOGICALS	$64,027,000	$36,560,000
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$25,772,000	$20,953,000
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$25,617,000	$9,726,000
ANTIVIRALS	$17,339,000	$15,034,000
ANTICOAGULANTS	$15,830,000	$11,112,000
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$15,775,000	$6,798,000
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$11,656,000	$10,867,000
ENDOCRINE AND METABOLIC AGENTS - MISC.	$11,013,000	$5,481,000

Data for Publication on Commissioner Website

Masked PBM ID	A22PY2
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
0	0	0

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$ 361,000	$ 43,000	$ 14,000	$ 57,000	$ -	$ -	$ -	$ 304,000

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Analgesics	$ 96,000.00	$ 83,000
Respiratory Tract/Pulmonary Agents	$ 36,000.00	$ 30,000
Anesthetics	$ 30,000.00	$ 29,000
Central Nervous System Agents	$ 29,000.00	$ 17,000
Anticonvulsants	$ 27,000.00	$ 23,000
Blood Glucose Regulators	$ 25,000.00	$ 21,000
Anti-Addiction/Substance Abuse Treatment Agents	$ 22,000.00	$ 19,000
Antivirals	$ 12,000.00	$ 11,000
Ophthalmic Agents	$ 10,000.00	$ 9,000
Skeletal Muscle Relaxants	$ 10,000.00	$ 9,000

Data for Publication on Commissioner Website

Masked PBM ID	AWLIW9
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments Percentage

Across All Plan Sponsors	Highest	Lowest	Mean
	100.00%	0.00%	3.51%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$112,962,898	$21,367,669	$2,061,519	$33,506,750	$21,367,669	($546,738)	0.00%	$79,456,147

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
IMMUNOLOGICAL AGENTS	$26,975,584	$16,657,232
BLOOD GLUCOSE REGULATORS	$18,731,193	$7,220,228
DERMATOLOGICAL AGENTS	$11,059,650	$7,328,420
RESPIRATORY TRACT/PULMONARY AGENTS	$9,972,402	$7,818,933
CENTRAL NERVOUS SYSTEM AGENTS	$8,587,429	$6,880,438
ANTINEOPLASTICS	$4,689,614	$4,599,096
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	$3,673,082	$2,551,449
GENETIC OR ENZYME DISORDER: REPLACEMENT, MODIFIERS, TREATMENT	$3,412,577	$2,967,842
CARDIOVASCULAR AGENTS	$2,902,975	$2,792,535
ANTIVIRALS	$2,664,739	$2,493,989

Data for Publication on Commissioner Website

Masked PBM ID	C6DERB
Data Period	CY2021

Retained Rebates and Other Fees and Payments

Percentage Across All Plan Sponsors	**Highest**	**Lowest**	**Mean**
	20%	0%	10%

Totals During Data Period	**WAC**	**Rebates**	**Other Fees and Payments**	**Total Rebates and Other Fees and Payments**	**Total Rebates and Other Fees and Payments - Non Plan Sponsor**	**Retained Rebates and Other Fees and Payments - Non Plan Sponsor**	**Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor**	**Net WAC**
	$ 103,098,075	$ 22,809,360	$ 1,063,515	$ 23,872,875	$ 22,809,360	$ 4,561,881	20%	$ 79,225,200

Top 10 Categories by Spend - Descending Order

Therapeutic Category	**WAC**	**net WAC**
IMMUNOLOGICAL AGENTS > IMMUNOSUPPRESSANTS	$ 20,997,027	$ 13,165,334
IMMUNOLOGICAL AGENTS > IMMUNOLOGICAL AGENTS, OTHER	$ 13,254,638	$ 10,229,366
BLOOD GLUCOSE REGULATORS > ANTIDIABETIC AGENTS	$ 6,843,046	$ 3,981,700
BLOOD GLUCOSE REGULATORS > INSULINS	$ 6,131,998	$ 3,294,864
CENTRAL NERVOUS SYSTEM AGENTS > MULTIPLE SCLEROSIS AGEN	$ 4,545,040	$ 3,790,265
ANTINEOPLASTICS > MOLECULAR TARGET INHIBITORS	$ 4,187,546	$ 4,159,869
RESPIRATORY TRACT/PULMONARY AGENTS > RESPIRATORY TRACT	$ 2,876,405	$ 2,051,298
BLOOD PRODUCTS AND MODIFIERS > ANTICOAGULANTS	$ 2,328,999	$ 1,508,098
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SE	$ 2,238,134	$ 2,131,265
BLOOD PRODUCTS AND MODIFIERS > HEMOSTASIS AGENTS	$ 2,177,613	$ 2,150,374

Data for Publication on Commissioner Website

Masked PBM ID	CR9CVW
Data Period	CY2021

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
100%	100%	100%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	3,506,119	482,405	-	482,405	482,405	482,405	100%	3,023,714

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
ANALGESICS - OPIOID	$1,060,652	839,055
ANTICONVULSANTS	$423,720	416,724
DERMATOLOGICALS	$367,292	358,421
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$279,945	198,739
ANTIDEPRESSANTS	$195,161	191,113
ANALGESICS - ANTI-INFLAMMATORY	$141,903	141,903
MIGRAINE PRODUCTS	$127,041	86,155
ANTICOAGULANTS	$122,884	80,116
MUSCULOSKELETAL THERAPY AGENTS	$108,980	108,980
OPHTHALMIC AGENTS	$64,296	49,214

Data for Publication on Commissioner Website
Masked PBM ID GBSVRR
Data Period CY2021

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
4.88%	0.00%	2.46%

Totals During Data Period

WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Pavments - Non Plan Sponsor	Retained Rebates and Other Fees and Pavments - Non Plan Sponsor	Retained Rebates and Other Fees and Pavments Percentaze - Non Plan Sponsor	Net WAC
$135,937,386.00	$54,330,410.90	$137,788,289.67	$192,118,700.57	$372,374,151.06	$14,014,849.73	3.76%	-$56,181,314.57

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Blood Glucose Regulators	$44,884,534.00	-$28,151,145.24
Respiratory Tract/ Pulmonary Agents	$21,028,295.00	-$6,241,690.99
Central Nervous System Agents	$13,069,438.00	-$6,384,211.17
Blood Products/ Modifiers/ Volume Expanders	$8,358,255.00	-$3,139,837.40
Antineoplastics	$4,667,113.00	-$162,432.32
Dermatological Agents	$4,630,764.00	$2,087,186.15
Antidepressants	$4,566,159.00	-$2,091,259.86
Antipsychotics	$3,383,651.00	-$742,740.81
Gastrointestinal Agents	$3,198,233.00	-$1,822,615.32
Hormonal Agents. Stimulant/ Replacement/ Modifvi	$2,923,592.00	-$1,153,251.08

Data for Publication on Commissioner Website

Masked PBM ID	GXK8T7
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments

Percentage Across All Plan Sponsors	Highest	Lowest	Mean
	0.00%	0.00%	0.00%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$15,167,000	$1,409,000	$0.00	$1,409,000	$1,409,000	$0.00	0.00%	$13,758,000

Top 10 Categories by Spend - Descending Order

Therapeutic Category*	WAC	net WAC
ANALGESICS - ANTI-INFLAMMATORY	$3,326,000	$2,913,000
DERMATOLOGICALS	$1,917,000	$1,793,000
ANTIDIABETICS	$1,777,000	$1,627,000
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$1,028,000	$977,000
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	$773,000	$699,000
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$747,000	$692,000
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$588,000	$449,000
ANTIDEPRESSANTS	$371,000	$350,000
ENDOCRINE AND METABOLIC AGENTS - MISC.	$313,000	$264,000
ANTICOAGULANTS	$285,000	$257,000

*This PBM utilizes Medispan drug files, which are based on AHFS classification, and not USP. As a result, the therapeutic categories contained in this report are based on UHFS classifications rather than USP.

Data for Publication on Commissioner Website

Masked PBM ID	HGYHWR
Data Period	CY2021

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
100.00%	0.00%	12.95%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$113,054,265.12	$21,402,465.67	$2,268,882.68	$33,754,272.37	$21,609,254.55	($339,534)	0.00%	$79,299,992.75

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
IMMUNOLOGICAL AGENTS	$26,982,243.72	$16,656,174.38
BLOOD GLUCOSE REGULATORS	$18,740,030.93	$7,209,997.57
DERMATOLOGICAL AGENTS	$11,108,861.18	$7,345,509.47
RESPIRATORY TRACT/PULMONARY AGENTS	$9,973,884.84	$7,806,043.47
CENTRAL NERVOUS SYSTEM AGENTS	$8,589,300.88	$6,870,175.20
ANTINEOPLASTICS	$4,689,699.88	$4,598,352.70
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	$3,675,099.34	$2,549,502.68
GENETIC OR ENZYME DISORDER: REPLACEMENT, MODIFIERS, TREA	$3,412,577.10	$2,967,683.69
CARDIOVASCULAR AGENTS	$2,904,169.18	$2,751,294.78
ANTIVIRALS	$2,674,987.78	$2,502,057.41

Data for Publication on Commissioner Website

Masked PBM ID	KWV2JU
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments

Percentage Across All Plan Sponsors	Highest	Lowest	Mean
	100%	0%	32%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$1,105,142,000	$17,574,000	$908,309,000	$925,883,000	$19,963,000	$2,389,000	12%	

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Immunological Agents	$243,536,000	$13,550,000
Blood Glucose Regulators	$186,534,000	$17,117,000
Respiratory Tract/Pulmonary Agents	$93,758,000	$12,676,000
Antineoplastics	$82,524,000	$2,539,000
Central Nervous System Agents	$77,569,000	$9,578,000
Antivirals	$56,980,000	$7,973,000
Blood Products and Modifiers	$52,493,000	$8,852,000
Cardiovascular Agents	$38,959,000	$22,482,000
Dermatological Agents	$29,425,000	$12,867,000
Antidepressants	$27,057,000	$12,166,000

Data for Publication on Commissioner Website

Masked PBM ID	QMYBPZ
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
5%	0%	3%

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$ 1,538,030.53	$ 364,290.66	$ -	$ 364,290.66	$ 364,290.66	$ 15,153.58	4%	$ 1,173,739.88

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Immunological Agents	$387,211	$304,881
Antineoplastics	$288,034	$288,034
Blood Glucose Regulators	$265,654	$150,976
Products Without a USP Category	$111,651	$89,401
Respiratory Tract/Pulmonary Agents	$82,726	$50,655
Blood Products and Modifiers	$58,007	$41,209
Dermatological Agents	$56,321	$40,465
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)	$49,936	$17,093
Antivirals	$42,540	$40,814
Cardiovascular Agents	$34,986	$24,270

Data for Publication on Commissioner Website

Masked PBM ID	RK6UF7
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
100	-34	7

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	2113036000	356932000	1928206000	2285154000	361503000	905000	-10	-172126000

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Immunological Agents	455472000	-45620000
Blood Glucose Regulators	335612000	-105749000
Respiratory Tract/ Pulmonary Agents	178078000	-18216000
Antineoplastics	138136000	-3366000
Central Nervous System Agents	133125000	-1299000
Unclassified	124691000	-33512000
Antivirals	113439000	2583000
Blood Products and Modifiers	82208000	-4750000
Antipsychotics	62761000	-1083000
Cardiovascular Agents	54245000	7367000

Data for Publication on Commissioner Website

Masked PBM ID	SJNM6K
Data Period	CY2020

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
$410.90	$37.57	$50.30

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
Total	$273,342.65	$16,543.07	$704.80	$17,247.87	$0.00	$0.00	$0.00	$256,094.78

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Analgesics - Opioid	$99,264.44	$93,787.52
Antipsychotics	$34,011.75	$33,063.19
Anticonvulsant (Neuropathic Pain Agents)	$25,641.69	$24,502.23
Antiasthmatic Agents	$20,642.68	$17,718.00
Anticoagulants	$20,503.45	$19,002.88
Antidepressants	$14,837.00	$14,098.32
Dermatological	$11,947.08	$11,571.21
Migraine Products	$8,382.53	$7,867.99
Ophthalmic Agents	$8,327.22	$7,335.94
Misc GI Agents	$7,649.59	$6,907.04
Misc Psychotherapeutic and Neurological Agents	$7,646.86	$7,178.41
Analgesics - Anti-Inflammatory NSAIDs	$6,981.06	$6,376.05
Antihyperlipidemic Agents	$3,240.00	$2,992.28
Sedative Hypnotics	$3,006.93	$2,718.19
Antidotes	$750.00	$514.45
Antidiabetic Agents	$510.37	$461.08

Data for Publication on Commissioner Website

Masked PBM ID	XPJRDH
Data Period	**CY2021**

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors

Highest	Lowest	Mean
0	0	0

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC
	$ 973,000.00	0	0	0	0	0	0	973000

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
Analgesics	$ 489,000.00	$ 489,000.00
Anesthetics	$ 37,000.00	$ 37,000.00
Antibacterials	$ 3,000.00	$ 3,000.00
Anticonvulsants	$ 104,000.00	$ 104,000.00
Antidepressants	$ 116,000.00	$ 116,000.00
Antiemetics	$ 2,000.00	$ 2,000.00
Antimigraine Agents	$ 39,000.00	$ 39,000.00
Antiparkinson Agents	$ 20,000.00	$ 20,000.00
Antipsychotics	$ 1,000.00	$ 1,000.00
Antispasticity Agents	$ 12,000.00	$ 12,000.00
Antivirals	$ 7,000.00	$ 7,000.00
Anxiolytics	$ 3,000.00	$ 3,000.00
Blood Products and Modifiers	$ 33,000.00	$ 33,000.00
Cardiovascular Agents	$ 1,000.00	$ 1,000.00
Central Nervous System Agents	$ 16,000.00	$ 16,000.00
Dermatological Agents	$ 12,000.00	$ 12,000.00
Gastrointestinal Agents	$ 31,000.00	$ 31,000.00
Genetic, Enzyme, or Protein Disorder: Replacement, Modifiers, Treatment	$ 2,000.00	$ 2,000.00
Genitourinary Agents	$ 8,000.00	$ 8,000.00
Inflammatory Bowel Disease Agents	$ 2,000.00	$ 2,000.00
Ophthalmic Agents	$ 24,000.00	$ 24,000.00
Otic Agents	$ 3,000.00	$ 3,000.00
Skeletal Muscle Relaxants	$ 5,000.00	$ 5,000.00
Sleep Disorder Agents	$ 3,000.00	$ 3,000.00

Appendix

Public Pharmacy Benefit Manager (PBM) Transparency Report 2022

Appendix

The transparency reporting FAQ was developed based on anticipated questions from PBMs on the reporting process, requirements, and parameters. The initial FAQ was submitted to all licensed PBMs on August 31, 2020, and then updated on September 21, 2020 based on feedback and additional questions received from PBMs. The Department did not receive additional questions from PBMs that could not be answered by the FAQ. No content changes were made to the FAQ for 2022.

This document was developed in August 2020 and finalized in September 2020 after incorporating feedback of licensed PBMs and other stakeholders. The template requires PBMs to populate data at the individual claims level detail for claims processed for enrollees of plan sponsors doing business in Minnesota. The data fields are based on the list of data required under Minn. stat. § 62W.06, subd. 2(7)(a)(i)-(x). The Department made no substantive changes to the template for 2022.

This document was developed in August 2020 and finalized in September 2020 after incorporating feedback of licensed PBMs and other stakeholders. The template requires PBMs to populate data at the Therapeutic Category level, and summarizes a number of items regarding prescription drug prices, related rebates by therapeutic category, and overall wholesale acquisition costs for all plan sponsors doing business in Minnesota. The data fields are based on the list of data required under Minn. stat. § 62W.06, subd. 2 (a)(1)-(6). There were no substantive changes made to the template for 2022.

This document was listed as the Public Report recommendation in the 2020 Appendix and was sent to PBMs in September 2020 with a request for feedback. The Department finalized the template after receiving no additional feedback. The template contains data fields required under Minn. Stat. § 62W.06, subd. 2 (b), forming public reports for each PBM. For 2022 reporting, the Department requested that PBMs fill out this as a required template in addition to the aggregate and claim level templates.

This letter includes reminders of requirements for transparency reporting under Minn. stat. § 62W.06, subd. 2. This letter was submitted to all licensed PBMs along with the templates and FAQ. The letter conveys the expectation that (when applicable) the claims level detail, aggregate report, and public report templates must all be submitted to the Department in order to fulfill transparency reporting requirements. The letter also explained that PBMs exempt from reporting requirements must submit zero reports for each template as well as accompanying rationale for the reported exemption. See the attached FAQ for additional information on rationale exempting PBMs from certain transparency reporting requirements.

Transparency Reporting FAQ

The transparency reporting FAQ was developed based on anticipated questions from PBMs on the reporting process, requirements, and parameters. The initial FAQ was submitted to all licensed PBMs in August, 2020, and then updated in September, 2020 based on feedback and additional questions received from PBMs. The Department did not receive additional questions from PBMs that could not be answered by the FAQ. No content changes were made to the FAQ for 2021, and the document was sent to all PBMs in April and May 2022.

PBM Transparency Reporting Frequently Asked Questions

Q: How will the department distribute the final reporting templates and data dictionary?

Answer: The Department will distribute the final templates, data dictionary, and any other material associated with the reporting via email to the contact listed on the PBM's most recent licensure form.

Q: Should invoiced rebates be included in aggregate rebate reporting?

Answer: Yes. The statutory definition of rebates given in 62W.02 subd. 17 includes "… discounts and concessions based on actual or estimated utilization of a prescription drug. Rebates also include price concessions based on the effectiveness of a prescription drug as in a value-based contract." This definition encompasses rebates that may be collected at the time of reporting or, in the case of value-based contracts, may be estimated or invoiced. As such the Commissioner's report asks for all rebates associated with the reporting claims, including those invoiced or estimated.

Q: How should high, low, and mean retained rebate percentages be calculated if a PBM only has one plan sponsor?

Answer: Any information published on the Department of Commerce's website will be done according to 62W.06 subd 2(b), and will not identify any plan sponsor. PBMs who report for two or more plan sponsors doing business in Minnesota will be able to calculate high, low, and mean retained rebate percentages. If a PBM only has one plan sponsor for their retained rebate report they should report that retained percentage and indicate it is from a sole plan sponsor. No information from the retained rebate report or any aggregate report will be published that identifies any plan sponsor.

Q: What constitutes a 'plan sponsor doing business in Minnesota'?

Answer: The aggregate reporting and claims-level detail should encompass data pertaining to all PBM clients who are plan sponsors doing business in Minnesota. The plan sponsor's status as doing business in Minnesota, not the location of the enrollee or dispensing pharmacies, dictates whether or not the data should be reported. Minnesota's PBM law defines a plan sponsor to include a single employer offering a health benefit plan, an employee organization, an association, joint board trustees, a committee, or other similar group. Additionally, the term is defined by reference to the

definition of a group purchaser in Minn. Stat. § 62J.03, subd. 6, which defines group purchasers as:

> A person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

A plan sponsor is considered to be doing business in Minnesota where the plan sponsor is a Minnesota entity, or it makes a contract or engages in a terms of service agreement with a resident of Minnesota to be performed in whole or in part by either party in Minnesota (e.g., offering of insurance coverage on the individual or group markets).

Q: If a PBM does not fit any of the criteria for reporting, what should they communicate to the Department?

Answer: The final templates for the Aggregate Report and Claims Level Detail Report include instructions on how to communicate a ‘zero report’ to the department. PBMs who believe they do not meet the requirements for reporting should review those instructions and communicate a ‘zero report’ to the Department accordingly.

Q: In the event a plan sponsor has contracts with multiple PBMs, how is reporting responsibility determined?

Answer: The Department’s goal is to reduce reporting duplication to the maximum extent possible. It is incumbent on PBMs who serve the same plan sponsor in different functions, or who are known subcontractors to PBMs serving plan sponsors to coordinate reporting to reduce duplication. The aggregate reporting workbook is required to be populated by PBMs with direct contractual relationships for plan sponsors doing business in MN for any PBM service that involves rebate administration, aggregation or the processing, payment or adjudication of prescription drug claims. In the instance that a PBM performs only some of those functions across their entire book of business of plan sponsors doing business in MN, some of those fields may be populated with ‘NA’. For example, if across their entire book of business, a PBM has a direct contractual relationship with plan sponsors only for claims processing, but not

rebate administration, aggregation, or processing, the PBM should report the WAC value of the claims by category, and 'NA' in the rebate fields.

The responsibility for reporting is guided by the direct, contractual, relationship with the plan sponsor for the given PBM activity. The entity with the direct contractual relationship is responsible for reporting. For example, if Plan Sponsor A contracts with PBM B for all PBM services, and PBM B subcontracts to TPA X for rebate aggregation, PBM B maintains responsibility for reporting the rebate data elements.

Q: What therapeutic category classification system is allowed for reporting?

Answer: The department has chosen to use US Pharmacopeia (USP) for the aggregate therapeutic category requirement. USP provides a free download of their category hierarchy with example drugs at www.usp.org. CMS also provides a free crosswalk of RxCUI to USP category which may assist plans with this requirement. This is part of CMS' Essential Health Benefits tools and is located at qhpcertification.cms.gov.

Q: What should a PBM report in field Patient Cost Sharing – Other Payer Amount if that value is not populated on their claim?

Answer: Not all claims or reporting entities will have populated values in the Patient Cost Sharing – Other Payer Amount field, defined as NCPDP field 566-J5. The report workbook indicates that if no other payer is identified on a claim a value of 0 can be entered in this field.

Q: What is included in the Total Paid to Pharmacy field?

Answer: The department is requesting a 'Total Paid to Pharmacy' field, defined as NCPDP field 505-F9. This field is the total amount paid to the pharmacy by the claims processor.

Q: How should PBMs identify claims requiring Prior Authorization?

Answer: The prior authorization field for the Commissioner's report should align with the PBM's formulary files or member publications. If a drug is published on a PBM's formulary with a prior authorization requirement, claims for that drug should be flagged as requiring prior authorization in the Commissioner's report.

Q: How should PBMs identify 'Preferred Pharmacies'?

Answer: Preferred pharmacies are defined from the perspective of the member's benefit design. In multi-tiered networks pharmacies on the tier with the lowest member cost sharing requirements should be designated as preferred. In flat networks, all pharmacies should be designated as preferred.

All specialty pharmacies should be designated as preferred unless multiple tiers of specialty pharmacies exist. If multiple tiers of specialty pharmacies exist, only those on the most preferred specialty tier (those with the lowest member cost sharing) should be identified as preferred.

Q: How should PBMs identify 'Mail Order Pharmacies'?

Answer: Mail order pharmacies should be identified according to the statutory definition given in MN 62W.01 subd8.

Q: In the event a wholesale acquisition cost (WAC) is not available for a product, what pricing reference should be used?

Answer: Licensees should use the wholesale acquisition cost (WAC) in the aggregate reporting template to approximate the pharmaceutical spend in each category. Only when a WAC is not available for a given product may alternative references (e.g. average wholesale price) be used to estimate the claim cost. If any alternative reference prices are used the licensee must indicate on the reporting template the percentage of spend in each category for which a WAC was not available and an alternative reference price was used. See the example below with columns A and B of the aggregate reporting template.

A	B
Therapeutic Category	**WAC**
Analgesics	$100,000
Anesthetics	$50,000[a]
Anti-Addiction/Substance Abuse Treatment Agents	$250,000

a. 0.5% of the spend in this category was calculated using a non-WAC reference price

Q: What should be done in the event a product could be mapped to multiple USP categories?

Answer: Reporting PBMs should reduce duplication whenever possible. In cases where a drug may be mapped to more than one USP category, the reporting PBM should chose only one category for that product. The choice of the category is at the discretion of the PBM and their clinical teams.

Q: What should be done in instances where a product cannot be mapped to a USP category?

Answer: Reporting PBMs should make every effort to map all products to a USP category whenever possible. For products that cannot be mapped to any category PBMs may create a separate category on the report titled *'Products Without a USP Category'*. This category should only be used in instances where a product or NDC cannot be reasonably assigned to an existing USP category by the PBM's clinical teams.

Q: For a PBM that does not process out of network claims, should all claims be flagged as being filled at a 'Required Pharmacy'?

Answer: Please refer to the 'Claims Level Detail' data dictionary and the 'Required Pharmacy' field definition. This field indicates whether enrollees are required by the plan to use the pharmacy. In closed networks, required pharmacies are all in-network pharmacies. In open networks all pharmacies are non-required, unless the product is exclusive to a particular provider (ie. specialty pharmacies).

Claims Level Detail Template

This document was developed in August 2020 and finalized in September 2020 after incorporating feedback from licensed PBMs and other stakeholders. The template requires PBMs to populate data at the individual claims level detail for claims processed for enrollees of plan sponsors doing business in Minnesota. The data fields are based on the list of data required under Minn. stat. § 62W.06, subd. 2(7)(a)(i)-(x). The Department made no substantive changes to the template for 2022.

Pursuant to Minn. Stat. § 62W.06, subd. 2 (7); all pharmacy benefit managers must submit the information requested in this document to the MN Department of Commerce. The data submitted should pertain to all plan sponsors doing business in Minnesota as defined by Minn. Stat. § 62W.02, subd.16 for the prior calendar year.

PBMs should identify themselves using their name and FEIN (columns R and S of this data dictionary) and populate those fields for every claim submitted.

Claims should be de-identified and should not contain any information that may identify a particular member, enrollee or patient. Claims should contain all fields listed on the [Data Dictionary] tab of this workbook.

Claims must be submitted by **June 1, 2022**. The Department will communicate instructions for submitting the claims to the appropriate upload site prior to the deadline.

Additional Notes on 'plan sponsor doing business in Minnesota': The plan sponsor's status as doing business in Minnesota, not the location of the enrollee or dispensing pharmacies, dictates whether or not the data should be reported. Minnesota's PBM law defines a plan sponsor to include a single employer offering a health benefit plan, an employee organization, an association, joint board trustees, a committee, or other similar group. Additionally, the term is defined by reference to the definition of a group purchaser in Minn. Stat. § 62J.03, subd. 6, which defines group purchasers as:

> A person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

A plan sponsor is considered to be doing business in Minnesota where the plan sponsor is a Minnesota entity, or it makes a contract or engages in a terms of service agreement with a resident of Minnesota to be performed in whole or in part by either party in Minnesota (e.g., offering of insurance coverage on the individual or group markets).

Inclusion Criteria: Unless specifically excluded below, data submitted should encompass all final paid pharmaceutical claims submitted on NCPDP transaction standards for plan sponsors doing business in Minnesota for whom the pharmacy benefit manager has a direct contractual relationship for any of the following PBM services as defined by Minn. Stat. § 62W.02, subd. 15:

-Contracting directy or indirectly with pharmacies to provide prescription drugs to enrollees or other covered individuals
-Administering the prescription drug benefit
-Processing or paying pharmacy claims
-Establishing a pharmacy network

Exclusion Criteria: Compound claims and claims for which the PBM is the secondary payer should be excluded.

Zero Reporting: If, based on the criteria above, your PBM does not have any claims detail reporting responsibilities to the Department complete the fields below and email this workbook to PBM.licensing@state.mn.us with the subject line 'Zero Report - Claims level detail' by **June 1, 2022 5pm CT**.

-PBM Name:
-PBM FEIN:
-Name and Title of PBM Contact:
-Contact Email:
-Contact Phone:

Field Letter	Field Name	Field Definition	Field Value(s)
A	Drug NDC	11-digit product NDC	11 digit NDC, no spaces or dashes
B	Drug Name	NDC-level drug name	Alphanumeric drug name, strength and dose form corresponding to NDC
C	Quantity	Quantity dispensed as indicated in NCPDP field 442-E7.	Unsigned numeric value populated in NCPDP field 442-E7, including decimal point
D	Prior Authorization	Indicator of whether or not the drug in the given claim in included on the PBM formulary and requires prior authorization as indicated on the PBMs drug formulary files or publications.	Y = Drug is on PBM formulary with prior authorization requirement N = Drug is on PBM formulary with no prior authorization requirement or drug is non-formulary
E	Patient Cost Sharing - Individual	Patient payment amount as indicated in NCPDP field 505-F5. Populate payment amount, not benefit structure or coinsurance level. For example - populate payment amount of 9.99; not coinsurance level of 10%.	Signed numeric value populated in NCPDP field 505-F5, including decimal point. Populate two digits to the right of decimal point.
F	Patient Cost Sharing - Other Payer Amount	Other payer amount as indicated in NCPDP field 566-J5.	Signed numeric value populated in NCPDP field 566-J5, including decimal point. Populate two digits to the right of decimal point. If no other payer is identified on the claim submit a value of 0.
G	Total Paid to Pharmacy	Amount paid to the pharmacy by the claims processor or PBM as indicated in NCPDP field 505-F9.	Signed numeric value populated in NCPDP field 505-F9, including decimal point. Populate two digits to the right of decimal point.
H	Fees or Other Assessments Paid by Pharmacy	Any fees or assessments charged to the pharmacy by the PBM associated with the given claim. Include any fee associated with the claim whether charged at the point of sale or determined retroactively.	Numeric value. Non-zero values must include decimal point. If no fees or assessments are associated with the claim submit a value of 0.
I	Net Amount Paid to Pharmacy	The amount paid to the pharmacy by the claims processor net other fees and assessments imposed on the pharmacy.	Calculate as (Field G - Field H). Populate a signed numeric value, including the decimal point. Populate two digits to the right of the decimal point.
J	Amount Charged to Plan Sponosor	The amount charged to the plan sponsor for the given claim.	Numeric value. Non-zero values must include decimal point and two digits to the right of the decimal point.
K	Pharmacy Claim Spread	Any difference between the Amount Charged to Plan Sponsor and the Net Amount Paid to Pharmacy for a given claim.	Calculate as (Field J - Field I). Non-zero values must include decimal point and two digits to the right of the decimal point.
L	Pharmacy NPI	National provider identification number of dispensing pharmacy	Ten digit NPI number
M	Pharmacy Name	Name of dispensing pharmacy	Name of dispensing pharmacy
N	Pharmacy Common Ownership	Indicator of whether or not the pharmacy is under common control or ownership with the pharmacy benefit manager. Pharmacies in which the PBM has any ownership stake should be identified as under 'common control or ownership.'	Y = Pharmacy is under common control or ownership with the pharmacy benefit manager N = Pharmacy is not under common control or ownership with the pharmacy benefit manager
O	Preferred Pharmacy	Indicator of whether or not the pharmacy is a preferred pharmacy under the plan. In multi-tiered networks, preferred pharmacies are defined as those on the most preferred tier according to the member's benefit design. In flat network designs, all pharmacies should be identified as preferred. Specialty pharmacies should be listed as preferred unless multiple tiers of specialty pharmacy exist. If multiple tiers exist, only the most preferred specialty pharmacies should be identified as preferred.	Y = Pharmacy is preferred N = Pharmacy is not preferred
P	Mail Order Pharmacy	Whether the pharmacy is, or is not, a mail order pharmacy as defined by 62W.01 subd. 8.	Y = Pharmacy is a mail order pharmacy N = Pharmacy is not a mail order pharmacy
Q	Required Pharmacy	Whether enrollees are required by the plan to use the pharmacy. In closed networks, required pharmacies are all in-network pharmacies. In open networks all pharmacies are non-required, unless the product is exclusive to a particular provider (ie. specialty pharmacies).	Y = Member is required to use this pharmacy N = Member is not required to use this pharmacy
R	PBM FEIN	FEIN of the PBM submitting the claim detail to the Commissioner	Nine digit FEIN, do not include the dash.
S	PBM Name	FEIN of the PBM submitting the claim detail to the Commissioner	Alphanumeric PBM name, may include spaces.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Drug NDC	Drug Name	Quantity	Prior Authorization	Patient Cost Sharing - Individual	Patient Cost Sharing - Other Payer Amount	Total Paid to Pharmacy	Fees or Other Assessments Paid by Pharmacy	Net Amount Paid to Pharmacy	Amount Charged to Plan Sponosor	Pharmacy Claim Spread	Pharmacy NPI	Pharmacy Name	Pharmacy Common Ownership	Preferred Pharmacy	Mail Order Pharmacy	Required Pharmacy	PBM FEIN	PBM Name

Aggregate Report Template

This document was developed in August 2020 and finalized in September 2020 after incorporating feedback from licensed PBMs and other stakeholders. The template requires PBMs to populate data at the Therapeutic Category level, and summarizes a number of items regarding prescription drug prices, related rebates by therapeutic category, and overall wholesale acquisition costs for all plan sponsors doing business in Minnesota. The data fields are based on the list of data required under Minn. stat. § 62W.06, subd. 2 (a)(1)-(6). There were no substantive changes made to the template for 2022.

Pursuant to Minn. Stat. § 62W.06, subd. 2; all pharmacy benefit managers must submit the information requested in this document to the MN Department of Commerce. The data submitted should pertain to all plan sponsors doing business in Minnesota as defined by Minn. Stat. § 62W.02, subd. 16 for the prior calendar year. Further guidance on plan sponsors is given in the [Contact and Parameters] tab.

Within 60 days of receipt of a completed report the comissioner will publish reported data from each PBM on the Department of Commerce website is accordance with Minn. Stat. § 62W.06, subd. 2(b).

Populate PBM contact information and review inclusion and exclusion criteria on the [Contact and Parameters] tab. Review the definitions on the [Definitions] tab, and populate the corresponding information for each report on the [TC Report] and [Retained % Report] tabs. Completed workbooks should be submitted to the Deparment via email at at PBM.licensing@state.mn.us no later than **June 1, 2022 5pm CT**.

Zero Reporting: If, based on the criteria above, your PBM does not have any aggregate reporting responsibilities to the Department complete the contact information fields on the [Contact and Parameters] tab along with a brief justification of why your PBM does not meet the criteria for aggregate reporting. Email the your workbook to the Department at PBM.licensing@state.mn.us with the subject line 'Zero Report - Aggregate reporting' by **June 1, 2022 5pm CT**.

PBM Name:

PBM FEIN:

Data Period:

Name and Title of PBM Contact:

Contact Email:

Contact Phone:

If submitting a Zero Report, explain why your PBM does not have aggregate reporting responsibility to the Department:

Additional Notes on 'plan sponsor doing business in Minnesota': The plan sponsor's status as doing business in Minnesota, not the location of the enrollee or dispensing pharmacies, dictates whether or not the data should be reported. Minnesota's PBM law defines a plan sponsor to include a single employer offering a health benefit plan, an employee organization, an association, joint board trustees, a committee, or other similar group. Additionally, the term is defined by reference to the definition of a group purchaser in Minn. Stat. § 62J.03, subd. 6, which defines group purchasers as:

> A person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

A plan sponsor is considered to be doing business in Minnesota where the plan sponsor is a Minnesota entity, or it makes a contract or engages in a terms of service agreement with a resident of Minnesota to be performed in whole or in part by either party in Minnesota (e.g., offering of insurance coverage on the individual or group markets).

Inclusion Criteria: Unless specifically excluded below, data submitted for this report should encompass all final paid pharmaceutical claims for plan sponsors doing business in Minnesota for whom the pharmacy benefit manager has a direct contractual relationship for any PBM service as defined by Minn. Stat. § 62W.02, subd. 15 that involve rebate administration or aggregation or the processing, payment or adjudication of prescription drug claims.

Definitions

Aggregate Report By Therapeutic Category All Plan Sponsors (TC Report)

Note: All dollar amounts should be rounded to the nearest thousand.

Column Letter	Column Name	Definition
A	Therapeutic Category	This column should be populated with the US Pharmacopeia (USP) therapeutic category name. Do not populate the report for categories with zero spend in the reporting period.
B	WAC	The total wholesale acquistion cost for products paid for in the given category during the reporting period. Only in instances where a WAC is not available for a given product may an alternative reference price (eg. Average wholesale price) be used. Place a superscript on any number in this column where alternative reference prices were used, and indicate in a footnote the percentage of spend that was calculated using a non-WAC reference price. See [TC report] tab for example.
C	Rebates	This column records all rebates associated with the pharmaceutical claims in the given category, including rebates invoiced but not yet collected. Rebates is further defined in MN 62W.02 as all price concessions paid by a drug manufacturer to a pharmacy benefit manager or plan sponsor, including discounts and other price concessions based on the effectiveness of a prescription drug as in a value-based or performance-based contract.
D	Other Fees and Payments	Any fees and payments, other than those defined as rebates, associated with the pharmaceutical claims in the given category from any source.
E	Total Rebates and Other Fees and Payments	Sum of Column C + Column D
F	Total Rebates and Other Fees and Payments - Non Plan Sponsor	The total amount of rebates and other fees and payments, except those directly from plan sponsors, attributable to claims in the given category.
G	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	The total amount of rebates and other fees and payments, except those directly from plan sponsors, that are retained by the pharmacy benefit manager as revenue for services provided.
H	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	The amount of rebates and other fees and payments, except those directly from plan sponsors, that are retained by the pharmacy benefit manager as revenue for services provided stated as a percentage of the total collected. (Column G/Column F)*100; report number as a percentage.
I	Net WAC	The total wholesale acquistion cost for products paid for in the given category minus all rebates, other fees, and payments to the PBM associated with those claims. (Column B - Column E)

Retained Rebate and Other Fees and Payments Percentage Across All Plan Sponsors (Retained % Report)

Note: All percentages should be rounded to the nearest whole number

Column Letter	Column Name	Definition
J	Highest	Across all plan sponsors in the reporting period, the highest retained rebates and other fees and payments percentage for all utilization of any given plan sponsor. The retained rebates and other fees and payments percentage is calculated as in column H of the TC Report.
K	Lowest	Across all plan sponsors in the reporting period, the lowest retained rebates and other fees and payments percentage for all utilization of any given plan sponsor. The retained rebates and other fees and payments percentage is calculated as in column H of the TC Report.
L	Mean	Across all plan sponsors in the reporting period, the mean retained rebates and other fees and payments percentage for all utilization of any given plan sponsor. The retained rebates and other fees and payments percentage is calculated as in column H of the TC Report.

Aggregate Report By Therapeutic Category All Plan Sponsors (TC Report)

PBM Name:
PBM FEIN:
Data Period:
Note: Report all claims by Therapeutic Category and in total. Do not report categories with zero spend. All dollar amounts should be rounded to the nearest thousand.

A	B	C	D	E	F	G	H	I
Therapeutic Category	**WAC**	**Rebates**	**Other Fees and Payments**	**Total Rebates and Other Fees and Payments**	**Total Rebates and Other Fees and Payments - Non Plan Sponsor**	**Retained Rebates and Other Fees and Payments - Non Plan Sponsor**	**Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor**	**Net WAC**
USP Example Cat A	$100,000[a]	$4,000	$2,000	$6,000	$4,500	$1,000	22.20%	$94,000
USP Example Cat B								
USP Example Cat C								
...								
Total								

a) 0.5% of spend in USP Example Cat A was calculcated using an alternative (non-WAC) reference price

Retained Rebate and Other Fees and Payments Percentage Across All Plan Sponsors (Retained % Report)

PBM Name:

PBM FEIN:

Data Period:

Note: All percentages should be rounded to the nearest whole number

	J	K	L
Retained Rebates and Other Fees and Payments Percentage	**Highest**	**Lowest**	**Mean**

Public Report Template

This document was listed as the Public Report Recommendation in the 2020 Appendix and was sent to PBMs on September 28, 2020 with a request for feedback. The Department finalized the template. The template contains data fields required under Minn. Stat. § 62W.06, subd. 2 (b), forming public reports for each PBM. For 2022 reporting, the Department requested that PBMs fill out this as a required template--in addition to the aggregate and claim level templates.

Data for Publication on Commissioner Website
Masked PBM ID [redacted]
Data Period CY2021

Retained Rebates and Other Fees and Payments Percentage Across All Plan Sponsors	Highest	Lowest	Mean

Totals During Data Period	WAC	Rebates	Other Fees and Payments	Total Rebates and Other Fees and Payments	Total Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments - Non Plan Sponsor	Retained Rebates and Other Fees and Payments Percentage - Non Plan Sponsor	Net WAC

Top 10 Categories by Spend - Descending Order

Therapeutic Category	WAC	net WAC
USP Example Cat 1		
USP Example Cat 2		
USP Example Cat 3		
USP Example Cat 4		
USP Example Cat 5		
USP Example Cat 6		
USP Example Cat 7		
USP Example Cat 8		
USP Example Cat 9		
USP Example Cat 10		

Transparency Reporting Updates Letter

This letter includes reminders of requirements for transparency reporting under Minn. stat. § 62W.06, subd. 2. The letter also includes updates for 2022. The letter conveys the expectation to all licensed PBMs that the three templates (included with the letter) must be submitted to the Department to fulfill transparency reporting requirements.

March 31, 2022

To: All Licensed Pharmacy Benefit Managers (PBMs)

From: Minnesota Department of Commerce
85 7th Pl E, Suite 280
St Paul, MN 55101

RE: 2022 transparency reporting requirements

This letter provides guidance, updated for 2022, around pharmacy benefit manager (PBM) transparency reporting requirements pursuant to Minn. Stat. §62W.06, subdivision 2. All actively licensed PBMs doing business in the State of Minnesota must submit a transparency report to the Department of Commerce. Transparency reports must include claims level and aggregate data for the previous calendar year. **All licensed PBMs must submit a response to the Department by June 1, 2022.**

Reporting materials attached to this letter

This letter serves as a reminder of the upcoming reporting deadline, and also clarifies requirements the Department has communicated previously. Additionally, this letter incorporates newly codified requirements for transparency reporting recently adopted under Minnesota Rules 2737. The following attachments are also included for reference:

- Aggregate Report Template
- Claims Level Detail Template
- Public Report Template
- Transparency Reporting FAQ

The first three templates and the FAQ remain unchanged from 2021. The first two templates are required to be used for submission, even when providing notification of zero data to report. The Public Report Template is required for any PBM reporting data under the Aggregate Report Template.

Reminders and clarifications for 2022

Every licensed PBM must submit a response to this letter. All responses from reporting entities must include the **first two templates**, whether or not the given PBM has data to report. Included below are all reporting scenarios the Department has identified, and their corresponding expectations for submission:

Scenario	Report Types Required	Add'l Information Required
PBM contracts with plan sponsors doing business in MN and has reportable data under Minn. Stat. §62W.06, subd. 2	Aggregate Report Claims Level Detail Report Public Report	None
PBM contracts with plan sponsors doing business in MN and has **no** reportable data under Minn. Stat. §62W.06, subd. 2	Zero Aggregate Report Zero Claims Level Detail Report	Detailed rationale for submission of zero reports
PBM contracts with plan sponsors doing business in MN and has **partial** reportable data under Minn. Stat. §62W.06, subd. 2	Zero Aggregate Report OR Aggregate Report Zero Claims Level Detail Report OR Claims Level Detail Report Public Report	Detailed rationale for submission of zero reports

All PBMs must follow one of the options above, depending on each PBM's assessment of what information they are required to report to Commerce. Contact the Department as soon as possible with questions regarding reporting requirements. PBMs are reminded that, per Minnesota statute, failure to comply with reporting requirements may result in a fine of $1000 per day.

Reporting Templates and Submission

The Department requires all licensed PBMs to use the attached Aggregate, Claims Level Detail, and Public Report templates where appropriate. The Department will not publish any data considered to be trade secret or outside the scope of Minn. Stat. §62W.06, subd. 2. Each template required for submission contains multiple tabs with instructions and definitions for use.

The Aggregate and Claims Level Detail templates must be used when reporting zero data to the Department. If a PBM has determined it does not have reporting responsibilities, each template should be completed as a "zero report," and accompanied by a brief written justification to the Department regarding the basis of non-reporting. PBMs are not expected to use and submit the public report template unless there is data submitted on either of the previous templates that would necessitate it.

The Department will continue to expect use of the United States Pharmacopeia (USP) for aggregate reporting data. As a reminder, USP provides a free download of their category hierarchy with example drugs at www.usp.org. CMS also provides a free crosswalk of RxCUI to USP category which may assist plans with this requirement. This is part of CMS' Essential Health Benefits tools and is located at qhpcertification.cms.gov.

Templates must be completed by PBMs to the full extent possible based on the data available for reporting to the Department. In the event certain data elements are not available (such as USP category or wholesale acquisition cost) it should be noted within the template accordingly.

The Department previously required use of Box for secure file transfers of transparency reporting data. For 2022 reports, the Department is no longer requiring use of this secure transfer site. The Department will be accepting submissions through the State secure file transfer protocol (SFTP) and will invite all licensed PBMs to upload files. If there are any issues utilizing the state SFTP, the Department will accept submission of reports from the reporting entity via secure email.

Public Reporting

The Department is required to publish a public report within 60 days of receiving a PBM's transparency report,and thus the Public Report Template is the material that will be posted on Commerce's website, except in cases where we receive an Aggregate Report from a PBM and no accompanying Public Report Template—**in such situations, the Department will publish the Aggregate Report submitted by that PBM as the public version.**

Obtaining consistent data is crucial to producing public reporting. If any of the reporting information in the templates requires clarification, please contact the Department as soon as possible.

Please email andrew.kleinendorst@state.mn.us and PBM.Licensing@state.mn.us with questions regarding transparency reporting.