Pharmacy Benefit Manager
2023 Annual Report
Comprehensive Instructions and Attestation

A. Introduction

New York law requires that each Pharmacy Benefit Manager (PBM) complete and submit an Annual Report to the New York State Department of Financial Services' (DFS) Bureau of Pharmacy Benefits by no later than July 1 each year.

Completion and submission of the following items, due on or before July 1, 2023, will constitute the second annual report:

- 2023 Annual Report Data Collection spreadsheet
- 2023 Annual Report Network Structure spreadsheet
- 2023 Annual Report Revenue by Service Category spreadsheet
- 2023 Annual Report Narrative Response PDF fillable
- 2023 Annual Report Attestation (included in this document) PDF fillable

Do not modify or otherwise change these items' templates, including their file formats.

Failure to complete an annual report may result in a civil penalty.

Under Section 2904(c) of the Insurance Law, all information, documents, and material disclosed by a pharmacy benefit manager under this section and in the possession or under control of the superintendent shall be deemed confidential and not subject to disclosure except where and as the superintendent determines that disclosure is in the public interest.

B. General PBM Information

PBM's Full Legal Name
New York State PBM Registration Number

C. Naming Conventions

All documents must be uploaded using the following naming conventions for all required items:

- Data Collection (PBM name)
- Network Structure (PBM name)
- Revenue (PBM name)
- Narrative (PBM name)
- Attestation (PBM name)

D. Definitions

The following definitions shall be used for all items contained in the second annual report unless otherwise stated:

- Health plan – An entity for which a pharmacy benefit manager provides pharmacy benefit management services and that is a health benefit plan or other entity that approves, provides, arranges for, or pays or reimburses in whole or in part for health care items or services, to include at least prescription drugs, for a substantial number of beneficiaries who work or reside in this state. The term a substantial number of beneficiaries who work or reside in this state means where 50 percent or more of the beneficiaries of the health plan work or reside in New York
- State-regulated health plan – An insurance company that is an authorized insurer under the insurance law, a company organized pursuant to article forty-three of the insurance law, a municipal cooperative health benefit plan established pursuant to article forty-seven of this the insurance law, an entity certified pursuant to article forty-four of the public health law, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of the insurance law, the state insurance fund, or the New York state health insurance plan established under article eleven of the civil service law. State-regulated health plans are a subset of the statutory term "health plan" defined above.

E. 2023 Annual Report Data Collection

This portion of the second annual report requires submission of data related to state-regulated health plans.

If the PBM does not have any such information to report, check here: ☐
If the box above was checked, explain in detail below why.

Each tab in the Data Collection spreadsheet requires the use of definitions and/or a data dictionary, and instructions unique to that tab. The sub-headings bolded below correspond with each tab.

a. State-Regulated Health Plans

1. Data Dictionary
    - Health plan name (NAIC) – The health plan's company name as it is recorded for National Association of Insurance Commissioner's identification purposes.
    - Health plan company number (NAIC) – The health plan's company number as it is recorded for National Association of Insurance Commissioner's identification purposes.
    - Health plan group number (NAIC) – The health plan's group number as it is recorded for National Association of Insurance Commissioner's identification purposes.
    - Covered members – A person who had health insurance coverage, regardless of whether the coverage is associated with an insurance policy, a group health plan, or an FEHB plan.
    - Average monthly covered members –
        - For each month of the calendar year, sum up the total number of covered members on a given day of the month.
        - Divide this number by 12 and round to the nearest tenth place.
    - Average monthly covered members in NYS –
        - For each month of the calendar year, sum up the total number of covered members located in NYS on a given day of the month.
        - Divide this by 12 and round to the nearest tenth.

b. Financials

1. Definitions
    - Claims cost – The total dollar amount paid, by a health plan, for the purpose of reimbursing a pharmacy for the ingredient cost of a prescription drug
    - Claims processing – The process by which prescription drug claims are processed by PBMs on behalf of health plan members.
    - Claims reimbursement – The process by which the PBM administers funds to pharmacies in the pharmacy network, that covers the cost of obtaining and dispensing prescription drugs.
    - Dispensing fees – A payment, not including reimbursement for ingredient cost, made by the PBM to the pharmacist/pharmacy related to filling a prescription for the drug, including to cover pharmacist/pharmacy costs associated with storing and preparing medications, and patient counseling.
    - Health plan administrative fees (rebate negotiation) – Administrative fees paid by the health plan to a PBM pursuant to a contract between the health plan and the PBM in connection with the PBM administering, invoicing, allocating, and collecting rebates.
    - Health plan administrative fees (claims processing/reimbursement) – Administrative fees paid by the health plan to a PBM pursuant to a contract between the health plan and the PBM in connection with the PBM's processing of the prescription claim and pharmacy reimbursement.
    - Manufacturer administrative fees – Administrative fees paid by the manufacturer to a PBM pursuant to a contract between the manufacturer and the PBM in connection with the PBM administering, invoicing, allocating, and collecting rebates.
    - Pharmacy administrative fees – Administrative fees paid by the pharmacy to a PBM pursuant to a contract between the pharmacy and the PBM in connection with claims processing and claims reimbursement.
    - Prescription drug – Aligning with the Centers for Medicare & Medicaid Services (CMS) reporting instructions (*see* pages 30-32 in the Prescription Drug Data Collection (RxDC) Reporting Instructions from CMS), a prescription drug is a set of National Drug Codes that are grouped together by name and ingredient.
    - Rebate negotiation – The process by which the PBM negotiates with the manufacturer on behalf of the health plan for competitive formulary placement to increase market share.
    - Rebate – Any actual or estimated/invoiced payment made directly or indirectly to a PBM by a manufacturer relating a drug's utilization, including the following: inflationary payments, credits, grants, reimbursements, incentives, inducements, refunds or other benefits received by the PBM, whether referred to as a rebate, discount, or otherwise.

2. Data Dictionary
    - Health plan name (NAIC) – The health plan's company name as it is recorded for National Association of Insurance Commissioner's identification purposes.
    - Health plan company number (NAIC) – The health plan's company number as it is recorded for National Association of Insurance Commissioner's identification purposes.
    - Health plan group number (NAIC) – The health plan's group number as it is recorded for National Association of Insurance Commissioner's identification purposes.
    - Manufacturer name – The name of the labeler, as recorded for the National Drug Code (NDC) directory.
    - Drug of interest type – The only accepted value for this column is utilization, claims cost, or rebates.
    - Prescription drug name – The prescription drug name, as defined by CMS. Report the prescription drug name as: ingredient name [brand name] for brand drugs and ingredient name for generic drugs (*see* pages 30-32 in the Prescription Drug Data Collection (RxDC) Reporting Instructions from CMS).

3. Instructions

    Use the following guidelines to determine the top 10 drugs for the following categories for each state-regulated health plan: utilization, claims cost, and rebates. Then, for each state-regulated health plan, report the required information for each prescription drug in accordance with the definitions provided.

    (1) Utilization
        (a) For each prescription drug name, locate the set of NDCs associated with the prescription drug name.
        (b) For this set of NDCs, locate all paid claims for the past calendar year.
        (c) Calculate the total prescription length for this collection of paid claims by adding together the length of the prescription for each paid claim.
        (d) Divide the total prescription length by 30 to calculate the total number of equivalent 30-day prescriptions dispensed by the calendar year.
        (e) Rank the brand prescription drugs according to the total number of equivalent 30-day prescriptions dispensed, in descending order.
        (f) Using this ranking, identify the 10 brand prescription drugs with the highest total number of equivalent 30-day prescriptions dispensed.

    (2) Claims Cost
        (a) For each prescription drug name, locate the set of NDCs associated with the prescription drug name.

(b) Calculate the total claims cost for the prescription drug name by adding together the total claims cost (for past calendar year) for each NDC in this set.
(c) Rank the prescription drugs according to the total claims cost, in descending order.
(d) Using this ranking, identify the 10 prescription drugs with the most rebates generated over the calendar year.

(3) Rebates
(a) For each prescription drug name, locate the set of NDCs associated with the prescription drug name.
(b) For each prescription drug, add the total rebates received by the PBM for each NDC in this set.
(c) Rank the prescription drugs according to the total rebates received by the PBM.
(i) In the case where all no rebates were collected across the entire formulary, make a note indicating this and report no information for this category.
(d) Using this ranking, identify the 10 prescription drugs with the most rebates generated over the calendar year.

c. Network Adequacy – Preferred and Open

1. Definitions
- Covered members – A person who had health insurance coverage, regardless of whether the coverage is associated with an insurance policy, a group health plan, or an FEHB plan.
- Non-preferred pharmacy – A pharmacy in the preferred pharmacy network that has “non-preferred” status in the network. As a result, covered drugs are offered to members at a lower out of pocket cost.
- Open network – A collection of pharmacies in a network, which is available to almost all pharmacies that are willing to provide price reductions to the plans. Participants in a plan can use their benefits for purchasing prescription drugs at any network pharmacy for the same copay or cost share amount.
- Preferred network – A collection of pharmacies with distinct cost-sharing options for preferred/non-preferred pharmacies, resulting in a lower out of pocket cost at preferred pharmacies.
- Preferred pharmacy – A pharmacy in the preferred pharmacy network that has a “preferred” status in the network. As a result, covered drugs are offered to members at a lower out of pocket cost.
- Specialty pharmacy – A pharmacy whose business focus is self-administered specialty products covered under a patient’s pharmacy insurance benefit.
- Specialty drugs – A prescription drug used to treat a chronic or specific disease or condition that requires frequent communication with other health care providers, extensive patient monitoring and case

management, and comprehensive counseling with the patient and/or caregiver.

2. Instructions
   Submission required if PBM provides pharmacy network management for health plan/sponsors.
   (1) Network Adequacy – Preferred
      (a) The reported information should be aggregated across all state-regulated health plans that contract with the PBM for pharmacy network management and all offered preferred pharmacy networks.
      (b) Report the required information as follows:
         (i) Average monthly covered members in NYS in 2022
            1. For each county of NYS, report the average number of monthly covered members:
               a. For each month in 2022, calculate the total monthly members by adding together the number of covered members, for each state-regulated health plan, that reside in the given county on a given day of the month.
               b. Add together the total monthly members for each month of the calendar year.
               c. Divide this total by 12 to calculate the average of monthly covered members.
         (ii) Average monthly covered members in NYS in 2021
            1. Repeat this process for calendar year 2021.
         (iii) For each county of NYS, report the following:
            1. Number of preferred/non-preferred non-specialty pharmacies in the network in 2022
            2. Number of preferred/non-preferred non-specialty pharmacies in the network in 2021
            3. Number of preferred/non-preferred specialty pharmacies in the network in 2022
            4. Number of preferred/non-preferred specialty pharmacies in the network in 2021
   (2) Network Adequacy – Open
      (a) The reported information should be aggregated across all state-regulated health plans that contract with the PBM for pharmacy network management and all offered open pharmacy networks.
      (b) Report the required information as follows:
         (iv) Average monthly covered members in NYS in 2022
            1. For each county of NYS, report the average number of monthly covered members:
               a. For each month in 2022, calculate the total monthly members by adding together the number of covered

members, for each state-regulated health plan, that reside in the given county on a given day of the month.
b. Add together the total monthly members for each month of the calendar year.
c. Divide this total by 12 to calculate the average of monthly covered members.

(v) Average monthly covered members in NYS in 2021
1. Repeat this process for calendar year 2021.

(vi) For each county of NYS, report the following:
1. Number of non-specialty pharmacies in the network in 2022
2. Number of non-specialty pharmacies in the network in 2021
3. Number of specialty pharmacies in the network in 2022
4. Number of specialty pharmacies in the network in 2021

F. 2023 Annual Report Network Structure

This portion of the second annual report requires submission of data related to all health plans.

If the PBM does not have any such information to report, check here: ☐
If the box above was checked, explain in detail below why.

Each tab in the Network Structure spreadsheet requires the use of a data dictionary and instructions unique to that tab. The sub-headings bolded below correspond with each tab.

a. Network Structure – Preferred and Open

1. Data Dictionary
   - Affiliated pharmacy A pharmacy that directly or indirectly through one or more intermediaries is owned by, controlled by, or is under common ownership or control of a pharmacy benefit manager, or where the pharmacy benefit manager has financial interest in the pharmacy. Chain

pharmacy – Retail pharmacies that operates within a chain of pharmacies – a corporate grouping of 4 or more pharmacies. This includes but is not limited to pharmacies within supermarkets and pharmacies within big-box stores.

- Independent pharmacy – Independently-owned and operated retail pharmacies that are not directly affiliated with any chain of pharmacies and are not owned by a publicly traded company.
- Long term care pharmacy (LTC) – A pharmacy supporting residential facilities that provide ongoing support for seniors/adults.
- Mail-order pharmacy – A pharmacy owned or operated by the PBM or an affiliate where prescriptions are filled and delivered to members by a mail delivery service.
- Non-preferred pharmacy – A pharmacy in the preferred pharmacy network that has "non-preferred" status in the network. As a result, covered drugs are offered to members at a higher out of pocket cost.
- Outpatient pharmacy – A pharmacy located within hospitals or clinics.
- Preferred pharmacy – A pharmacy in the preferred pharmacy network that has "preferred" status in the network. As a result, covered drugs are offered to members at a lower out of pocket cost.
- Specialty pharmacy – A pharmacy whose business focus is self-administered specialty products covered under a patient's pharmacy insurance benefit.
- 30-day equivalent prescription –The total number of prescriptions dispensed in the calendar year, converted to the equivalent number of 30-day prescriptions.

2. Instructions

   Submission required if PBM provides pharmacy network management for health plan/sponsors.

   (1) Network Structure – Preferred

   (a) The reported information should be aggregated across all health plans and offered preferred pharmacy networks.

   (b) Report the required information as follows:

   (i) Pharmacy breakdown:

   1. Number of preferred/non-preferred pharmacies in 2022:
      a. Create a list of all NYS pharmacies across all offered preferred networks, for each pharmacy type and affiliation status combination listed in the template.
      b. For each list generated, report the number of preferred/non-preferred pharmacies included.
   2. Number of preferred/non-preferred pharmacies in 2021:

a. Repeat this process for calendar year 2021.

(ii) Utilization:

1. Total units dispensed from preferred/non-preferred pharmacies (30-day equivalent) in 2022
    a. Compile all claims received by the PBM from the preferred/non-preferred pharmacies in each list generated as described above.
    b. Using these claims, add together the individual prescription lengths of the claims.
    c. Divide the total prescription length by 30 to complete the conversion to 30-day equivalent prescriptions.
    d. Report this number, rounded to the nearest hundredth place.
2. Total units dispensed from preferred/non-preferred pharmacies (30-day equivalent) in 2021
    a. Repeat this process for calendar year 2021.

(iii) Spending:

1. Total prescription revenue from preferred/non-preferred pharmacies in 2022
    a. Using the claims compiled as described above, add together the claims cost (dollar amount spent per claim)
    b. Report this number, rounded to the nearest hundredth place.
2. Total prescription revenue from preferred/non-preferred pharmacies in 2021
    a. Repeat this process for calendar year 2021.

(2) Network Structure – Open

(a) The reported information should be aggregated across all health plans and offered open pharmacy networks.

(b) Report the required information as follows:

(ii) Pharmacy breakdown:

1. Number of preferred/non-preferred pharmacies in 2022:
    a. Create a list of all unique pharmacies across all plans and networks, for each pharmacy type

and affiliation status combination listed in the template.
b. For each list generated, report the number of preferred/non-preferred pharmacies included.

2. Number of preferred/non-preferred pharmacies in 2021:
    a. Repeat this process for calendar year 2021.

ii. Utilization:
1. Total units dispensed from preferred/non-preferred pharmacies (30-day equivalent) in 2022
    a. Compile all claims received by the PBM from the preferred/non-preferred pharmacies in each list generated as described above.
    b. Using these claims, add together the individual prescription lengths of the claims.
    c. Divide the total prescription length by 30 to complete the conversion to 30-day equivalent prescriptions.
    d. Report this number, rounded to the nearest hundredth place.
2. Total units dispensed from preferred/non-preferred pharmacies (30-day equivalent) in 2021
    a. Repeat this process for calendar year 2021.

iii. Spending:
1. Total prescription revenue from preferred/non-preferred pharmacies in 2022
    a. Using the claims compiled as described above, add together the claims cost (dollar amount spent per claim)
    b. Report this number, rounded to the nearest hundredth place.
2. Total prescription revenue from preferred/non-preferred pharmacies in 2021
    a. Repeat this process for calendar year 2021.

G. 2023 Annual Report Revenue by Service Category

This portion of the second annual report requires submission of revenue related to all health plans.

If the PBM does not have any such information to report, check here: ☐ **If the box above was checked, explain in detail below why.**

The Revenue by Service Category spreadsheet has a self-contained set of instructions in the second tab. Follow these instructions.

H. 2023 Annual Report Narrative Response

This portion of the second annual report requires submission of narrative responses.

The Narrative Response PDF fillable has a self-contained set of instructions. Follow these instructions.

H. Attestation

The Annual Report must be signed and sworn to by an individual who is the Chief Executive of the PBM. A Chief Executive of the PBM is an officer, director, member, partner, or manager that holds the highest-ranking executive role of the PBM.

Full Legal Name of Chief Executive of the PBM
Position/Role

Read the statements below carefully and then check the boxes:
☐ I swear and affirm, under penalty of perjury, that the statements made in this Annual Report, including statements made in accompanying papers, have been examined by me and to the best of my knowledge and belief are true, correct, and complete.
☐ I understand that false statements made herein are punishable as a Class A misdemeanor pursuant to section 210.45 of the Penal Law.
Signature
Date