DEPARTMENT OF HEALTH

Minnesota Prescription Drug Price Transparency

REPORT TO THE MINNESOTA LEGISLATURE

April 2026

Minnesota Prescription Drug Price Transparency: 2026 Report to the Minnesota Legislature

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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The Honorable Paul Utke, Ranking Member
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The Honorable Erin Koegel, Co-Chair
5th Floor, Centennial Office Building

January 2026

To the Honorable Chairs and Ranking Members:

As directed in Minnesota Statutes 62J.84, the Minnesota Department of Health (MDH) collects, shares publicly, and reports on data under the Minnesota Prescription Drug Price Transparency Act (the Act). Enclosed is the fifth required legislative report with analysis of information reported to MDH by manufacturers of prescription drugs through the first half of 2025. The report also provides a program update that includes a preview of upcoming stakeholder engagement work in 2026 and an assessment of the impact of the Act.

Key findings from this report include:

- **Many prescription drug prices continue to rise at a significant rate—and the rate may be accelerating**. The average increase in price between 2020 and 2025 among drugs reported for a price increase was approximately 58%, which is more than two times higher than general inflation and nearly five times the cumulative rate of inflation for medical services. Further, the most recent year saw a particularly large jump in list prices—23% in the last year alone.
- **There is consistency in the types of medications for which manufacturers increase prices the most**. For the last three periods, the top three therapeutic classes by cost to payers and patients have been the same: *Anti-Inflammatory Pain Relievers*, *Dermatologicals* (drugs for skin conditions), and *Anti-Cancer Drugs.*
- **Net profits among reported drugs account for notable health care spending in Minnesota**. Based on data reported by manufacturers, the average net profit margin among drugs reported for a price increase between July 2024 and June 2025 ranged from 13% for brand biologic drugs to 29% for generic small molecule drugs (overall average of 22%). Based on the reported profit margins, MDH estimates that nearly $90 million of gross payments reported to the Minnesota All Payer Claims Database (MN APCD) on reported price growth drugs went to manufacturers' profits. More than $2.5 million came from patient cost sharing.

Taken together, the findings reflect significant complexity and persistent price growth in the prescription drug markets in the United States. This challenges patient access and affordability and indicates that more is needed to manage drug prices.

This report and the publicly available data reported by prescription drug manufacturers are available on the MDH website for research under the Act (Prescription Drug Price Transparency Research and Analysis - MN Dept. of Health).

Questions or comments on the report may be directed to Stefan Gildemeister, the state health economist, at (651) 201-4520, or health.Rx@state.mn.us.

Sincerely,

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Contents

Executive summary

The Prescription Drug Price Transparency Act or "the Act" (Minnesota Statutes 62J.84[1]) requires that the Minnesota Department of Health (MDH) collect data on prescription drug prices, make it publicly available, and submit annual reports to the Legislature. These activities aim to promote transparency in pharmaceutical pricing in Minnesota, enhance understanding of pharmaceutical spending trends, and assist the state and other payers in the management of pharmaceutical costs.

Since the Minnesota Legislature passed the Act in 2020, the need for transparency in pharmaceutical pricing and assistance in managing pharmaceutical costs has only continued to grow: employers, health plans, and Minnesotans continue to report the impact of rising drug costs. In 2022 and 2023, employers in Minnesota reported increases to family insurance premiums of over 18% to $23,852. In 2025, nationally reported increases in health care premiums were 6% for employers and 26% for small group and individual market insurers. Analysts noted the rising cost of prescription drugs as a primary factor contributing to these increases. Similarly, Minnesotans with and without insurance have also shared stories with MDH detailing the efforts and sacrifices made to afford medications and the worries of no longer having access to needed medications.

Reporting and insights

The Act helps identify emerging patterns in pharmaceutical spending and provides insights into the impact of supply chain entities (manufacturers, wholesalers, prescription benefit managers, and pharmacies) on drug spending that enhance understanding of pharmaceutical spending. Key findings from MDH's analysis of transparency data include:

- New Drugs:
  - Of the new drug introductions that required reporting, the median list price—or wholesale acquisition cost (WAC)—for a new brand drug was $5,560; however, 25% of new brand drug introductions (76 drug products) had a list price of price of more than $20,252.
  - *Anti-cancer drugs* was the top therapeutic category by number of reportable new drug introductions for three of the four time periods for which MDH has collected new drug information.
- Price Growth:
  - The average increase in price between 2020 and 2025 among drugs reported because of a price increase was approximately 58%, which is more than two times higher than general inflation and nearly five times the cumulative rate of inflation for medical services. The most recent year saw a particularly large jump in list prices—23% in the last year alone.
  - For the last three time periods of analysis, the top three therapeutic classes by cost to payers and patients have been the same: ***Anti-Inflammatory Pain Relievers***, ***Dermatologicals*** (drugs for skin conditions), and ***Anti-Cancer Drugs***.
  - Reportable prescription drugs with price growth—all of which are biologics—made up 31% of all payments in the ***Anti-Inflammatory Pain Relievers*** therapeutic class during calendar year 2024. Collectively, these drugs entailed $264 million in gross payments, of which $13 million of which came directly out of Minnesotan residents' pockets.
  - Finally, MDH finds that, based on data reported by manufacturers, the average net profit margin among drugs reported for a price increase between July 2024 and June 2025 ranged from 13% for

[1] Minnesota Statutes 62J.84 (https://www.revisor.mn.gov/statutes/cite/62J.84)

brand biologic drugs to 29% for generic small molecule drugs. Based on these calculated profit margins, MDH estimates that nearly $90 million of gross payments reported to the Minnesota All Payer Claims Database (MN APCD)[2] on reported price growth drugs went to manufacturers' profits, corresponding to an overall average net profit margin of 22%. More than $2.5 million in net profit is estimated to have come from patient cost sharing.

Takeaways

The Act continues to provide transparency data on high drug costs and insights into the prescription drug market as health care affordability in general—and pharmaceuticals in particular—is becoming increasingly challenging. This transparency and associated analysis will help identify potential policy options for policy makers to increase affordability. Since the Act's inception, MDH has identified thousands of price increases faced by Minnesota residents and health care payers, as well as hundreds of new drug introductions. Through this, Minnesota has made tremendous progress with drug price transparency, beginning to rectify the lack of public information that has long obscured prices and spending drivers.

While transparency is a starting point, meaningful efforts to drive down drug prices will require a multi-pronged approach via implementation of new policies and market regulation that support health care payers in managing prescription drug spending. Much of the responsibility for oversight of these issues lies with Congress or the federal government. In Minnesota, the Act's drug price transparency is enhanced by new work on drugs of substantial public interest, which takes a comprehensive view of the prescription drug supply chain. The state has also established a Prescription Drug Affordability Board, which has the authority to set upper payment limits. Most states, including Minnesota, now license PBMs—and some states have begun requiring that PBMs have a fiduciary duty to their health plan clients. States have also sought to improve access to medicines through regulating the use of prior authorization and step therapy, as well as through supporting small and independent pharmacies. The Act is one of many tools needed for patients, health insurers, and policy makers to understand the prescription drug market and manage prescription drug spending.

[2] Claims payment data reported to the MN APCD is provided before rebates. Because many of these are brand drugs, it is likely that the total amount paid by payers (health insurers and PBMs) is less than the gross figure due to rebate agreements between manufacturers and payers.

Introduction

The Prescription Drug Price Transparency Act or "the Act" (Minnesota Statutes 62J.84) requires that the Minnesota Department of Health (MDH) collect data on prescription drug prices, make it publicly available, and submit annual reports to the Legislature. These activities aim to promote transparency in pharmaceutical pricing in Minnesota, enhance understanding of pharmaceutical spending trends, and assist the state and other payers in the management of pharmaceutical costs.

Since the Minnesota Legislature passed the Act in 2020, the need for transparency in pharmaceutical pricing and assistance in managing pharmaceutical costs has only continued to grow: employers, health plans, and Minnesotans continue to report the impact of rising drug costs. In 2022 and 2023, employers in Minnesota reported increases in family insurance premiums of over 18% to $23,852.[3] In 2025, nationally reported increases in health care premiums were 6% for employers and 26% for small group and individual market insurers. Employers noted the rising cost of prescription drugs as a primary factor contributing to these increases.[4] Similarly, Minnesotans with and without insurance have also shared stories with MDH through an online form[5] detailing the efforts and sacrifices made to afford medications and the worries of no longer having access to needed medications:[6]

One individual shared: *"I work for a huge corporation, and I have to use drug manufacturer coupons and insurance to get my LIFE SAVING meds to $700/month."*

Another shared*: "I was diagnosed with an autoimmune disorder and…placed on [a drug that] helped stabilize my condition, [but] more recently, I was forced to switch my medication, and my appeal to stay on my medication was denied twice…I can only hope the new medication works as well."*

The Act prioritizes bringing transparency to the pricing of prescription drugs and supporting policy makers' continued efforts to understand the prescription drug market and conceive policy options to ensure Minnesotans can afford the medications they need. This report contains:

- A review of program updates and stakeholder engagement plans for 2026.

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[3] MDH, Health Economics Program. Chartbook Section 3: Employment-Based Health Insurance (https://www.health.state.mn.us/data/economics/chartbook/docs/section3.pdf).

[4] KFF. Annual family premiums for employer coverage rise 6% in 2025, nearing $27,000, with workers paying $6,850 toward premiums out of pocket (https://www.kff.org/affordable-care-act/annual-family-premiums-for-employer-coverage-rise-6-in-2025-nearing-27000-with-workers-paying-6850-toward-premiums-out-of-their-paychecks/). October 22, 2025; KFF. ACA insurers are raising premiums by an estimated 26%, but most enrollees could see sharper increases in what they pay (https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/). October 28, 2025.

[5] MDH, Health Economics Program. Prescription Drug Price Transparency Public Input Form (https://www.health.state.mn.us/data/rxtransparency/input.html).

[6] MDH collects stories, comments, and questions from Minnesota residents on their experiences paying for prescription drugs. Individuals may submit public input prescription drug pricing and share experiences associated with paying for prescription drugs online at MDH's Public Input on Prescription Drug Price Transparency in Minnesota form (https://forms.office.com/Pages/ResponsePage.aspx?id=RrAU68QkGUWPJricIVmCjJEFDds2GihEt42OkgoSyU1URFFVTE1VWFlFQ1JIMVVRQ09CUkdBWUpTOS4u).

- A summary of submitted information and analyses of reported data on drug price increases and new drug introductions between July 1, 2024, and June 30, 2025.
- An assessment of the impact of the Act.

Program Updates

Since the Act was established, the main objective has been to collect, maintain, and publicly post meaningful data on prescription drug prices. To that end, MDH has collected and organized reports on over 800 newly introduced drugs, 2,300 drugs with price increases, and 400 drugs considered to be of substantial public interest. These reports come from drug manufacturers, as well as wholesalers, pharmacy benefit managers (PBMs), and pharmacies. MDH is currently finalizing the publication of data submitted by over 1,400 reporting entities on the first list of drugs of substantial public interest, which focused on "high markup" drugs (Drugs of Substantial Public Interest: List Methodology and Summary, June 2024 (PDF)[7]). For more detail on program operations, please see Appendix B.

Stakeholder engagement in 2026

In 2026, one area of MDH's focus will be on further engaging with stakeholders working to manage prescription drug spending with the goal of identifying areas where transparency data can better support them.

- MDH is preparing for a new round of public input with an emphasis on getting input from Minnesota patients themselves, expanding beyond the online form referenced above to include new means of providing input, and raising awareness of the opportunity to share experiences paying for prescription drugs or to suggest topics to investigate through transparency.
- MDH is preparing for the release of analysis based on the first Drugs of Substantial Public Interest list. This list focused on "high markup" drugs, or drugs that were reimbursed by the insurer for more than 25% above manufacturers' list prices. Publications will focus on identifying the impacts these markups have on patients' out of pocket costs and health insurers' and employers' payments.
- MDH plans to follow this release with several "deep dive" conversations with Minnesota health care payers—health insurance carriers and self-funded employers—to explore what other data barriers they experience that future transparency efforts could address.

These efforts will build on prior MDH analysis and stakeholder engagement work aimed at equipping health care payers to manage prescription drug spending, as well as support other efforts within Minnesota to increase affordability of prescription drugs. For example, MDH provides technical assistance and data on drugs with high and quickly increasing prices to the Minnesota Prescription Drug Affordability Board to help inform their work to conduct cost reviews of prescription drugs and set payment limits. One Minnesota stakeholder expressed appreciation for the value these data provide to policy makers and health care payers amidst the complexity of the prescription drug supply chain's financial relationships and business transactions. MDH looks forward to greater engagement with health care payers and other stakeholders in 2026 on new ways to provide insights into prescription drug market functionality.

[7] Drugs of Substantial Public Interest: List Methodology & Summary, June 2024 (https://www.health.state.mn.us/data/rxtransparency/docs/drugspimethod.pdf)

Reporting and insights

The Act requires manufacturers to report certain drug price activity that meets statutory thresholds, including the introduction of high-priced new prescription drugs and large price increases on existing drugs (see Appendix B for more detail on the statute). This report refers to these introductions and price increases as *pricing events*. This section provides a summary of data submitted for pricing events and associated analysis of reference data for the period of July 1, 2024, to June 30, 2025.[8]

Data overview and compliance

Based on the Act's statutory thresholds, MDH expected reporting on 429 new drug introductions and 716 price growth events, of which approximately 59% and 64% were submitted, respectively. See Table 1 for a summary of required and submitted reports. MDH used several supporting data sources to identify reporting requirements and contextualize and deepen the understanding of findings from submitted reports—for a review of the sources used, please see Appendix B.

Table 1. Required and submitted reports, July 2024—June 2025

Report type	Required reports	Required and submitted reports	Percentage submitted
New drug reports	429	252	58.7 %
Price growth reports	716	457	63.8%
Total	**1,145**	**709**	**61.9%**

Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information about Medi-Span is available at: Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span); MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024 to June 30, 2025.

While MDH only received 64% of all required price growth reports, the data reported to MDH captures the vast majority of the portion of the market that requires reporting. The submitted reports represent 99.7% of the spending—that is, the 457 submitted reports accounted for about $585 million in gross spending reported to the APCD, while the 259 events that weren't reported only accounted for about $2 million in spending.[9]

New drug events

In the 12 months between July 2024 and June 2025, there were 429 new drug pricing events that met the Act's reporting threshold—that is, new drug products (NDCs) coming to market that have a list price greater than $950—representing 307 brand drugs and 122 generic drugs.[10] New brand drugs may be introduced upon Food

[8] See Table B1 in Appendix B for the statutory requirements for new drug and price growth reporting.

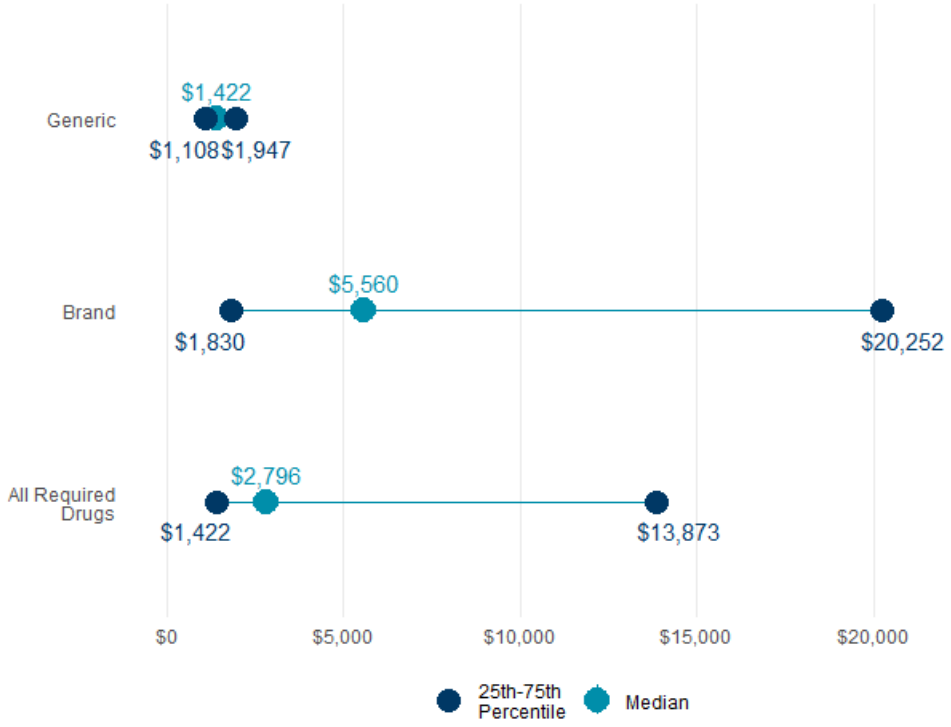
[9] Calculated using gross payments for NDCs meeting statutory thresholds as reported to the Minnesota All Payer Claims Database (MN APCD).

[10] This means that, upon introduction, the price of these drugs was $950 or more in 2024 and 2025. Additionally, for generic drugs, the price has to be within 15% of the reference brand drug.

and Drug Administration (FDA) approval of a new therapy and new generics may be introduced after the exclusivity period of the reference brand drug has expired.

Of the new drug introductions that required reporting, the median list price—or wholesale acquisition cost (WAC)—for a new brand drug was $5,560, while the median list price for a new generic drug was $1,422. Note that these measures do not represent the medians for *all* new drugs on the market—the prices for drugs that require reporting skew higher than the full universe of newly approved drugs because of the $950 statutory reporting threshold. Figure 1 displays the distribution of prices at introduction for required new drug introduction events at the 25th, 50th (median), and 75th percentiles.[11] It shows, for example, that the top 25% by list price of new brand drug introductions requiring reporting (which includes 76 drug products) had list prices of more than $20,252—reflecting that some classes of new drugs, such as gene therapies, can have very high introductory prices. The seven branded drug products with the highest introductory list prices were all gene therapies costing more than $200,000.

Figure 1. Price distribution for required new drug introductions—median price and 25th and 75th percentiles, July 2024 – June 2025



Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information at Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span); MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024 to June 30, 2025.

[11] A value at the 25th percentile means that 25% of the reported values are smaller and 75% are larger; likewise, a value at the 75th percentile means 75% of the reported values are smaller, and only 25% are larger. A value at the 50th percentile is at the median, which means half of the values are larger and half are smaller.

These numbers are largely consistent with previous reporting, albeit slightly increased, suggesting that the introductory price of new drugs is slowly increasing over time. In the 2025 Prescription Drug Price Transparency Report (PDF),[12] the median cost was $1,256 for generic drugs and $5,289 for brand drugs.

Types of new drugs

MDH analyzed required new drug reports and identified the most common therapeutic classes to help identify areas where increased drug innovation (many new drugs coming to market) is paired with high costs (the new drugs have a higher price). Figure 2 displays the 10 therapeutic classes with the greatest number of new drug introductions between July 2024 and June 2025 as well as their rank (by number of new drug products) since 2022 when data was first reported to MDH.

Key findings related to Figure 2:

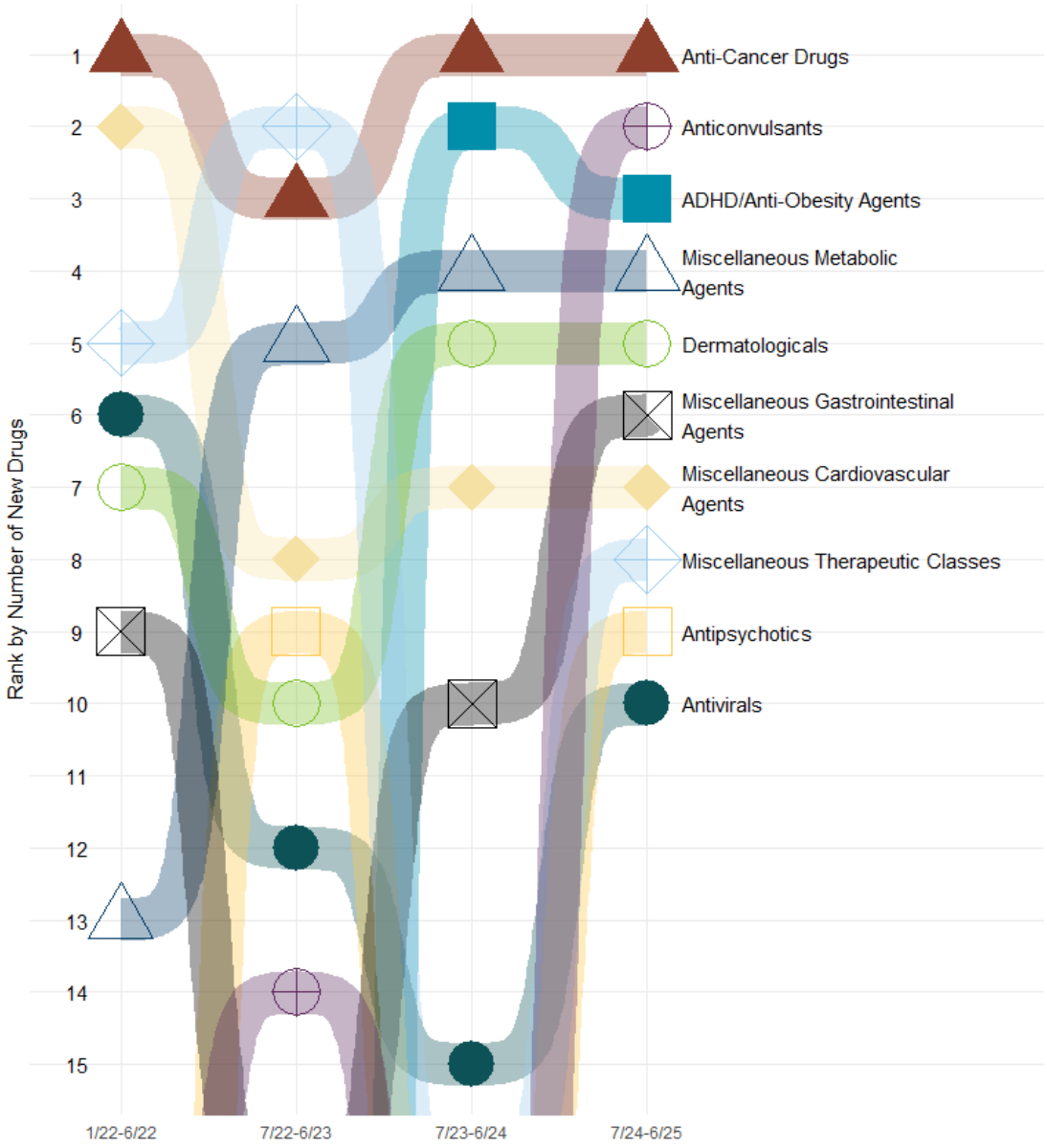
- With 91 high-priced new drugs (76 brand and 15 generic) this past year, ***Anti-Cancer Drugs*** was the top therapeutic category by number of new drug introductions. Cancer has been in the top two causes of death in the U.S. for more than 75 years[13] and is an area of major drug innovation.[14] Figure 2 shows that anti-cancer drugs were the most frequently introduced therapeutic class for three of the four time periods for which MDH has collected new drug reports.
- ***Anticonvulsants*** were the second-most common therapeutic class among required new drug reports, driven primarily by new generic drugs. This class of drugs was fourteenth-most common for required new drug reports between July 2022 and June 2023 but otherwise has not seen much high-priced innovation.
- ***ADHD and Anti-Obesity Agents*** were the third-most common therapeutic class this year, and were second-most common last year, but were not in the top 15 in the time periods prior to last year.
- Other therapeutic classes that have consistently been in the top 15 most common for required new drug reports are ***Miscellaneous Metabolic Agents***, ***Dermatologicals*** (driven by biologics treating autoimmune inflammatory conditions like plaque psoriasis and psoriatic arthritis), ***Miscellaneous Gastrointestinal Agents***, ***Miscellaneous Cardiovascular Agents*** (driven by drugs treating pulmonary arterial hypertension and heart failure), ***Miscellaneous Therapeutic Classes***, and ***Antivirals***.

[12] 2025 Prescription Drug Price Transparency Report (https://www.health.state.mn.us/data/rxtransparency/docs/rxlegrpt2025.pdf)

[13] Centers for Disease Prevention and Control. Cancer deaths - Health, United States (https://www.cdc.gov/nchs/hus/topics/cancer-deaths.htm)

[14] Dou, Yannan Nancy & Wang, Jian. Advancing Oncology Drug Development in the US: The Interplay between Innovations and Regulatory Science (https://link.springer.com/article/10.1007/s43441-025-00800-3). May 2025.

Figure 2. Top 10 therapeutic classes by number of new drug introductions, July 2024 – June 2025, and relative rank since January 2022[15]



Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information at [Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span)](https://www.wolterskluwer.com/en/solutions/medi-span); MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of January 1, 2022 to June 30, 2025.

[15] The following therapeutic classes were in the top 10 for other time periods. 1/22-6/22: 3—Allergenic Extracts, 4—Miscellaneous Hematological Agents, 8—Antidiabetics, 10—Anti-Inflammatory Pain Relievers; 7/22-6/23: 1—Neuromuscular Agents, 4—Miscellaneous Hematological Agents, 6—Allergenic Extracts, 7—Miscellaneous Neurological Agents; 7/23-6/24: 3—Anti-Inflammatory Pain Relievers, 6—Antidiabetics, 8—Hematopoietic Agents, 9—Passive Immunizing Agents.

Breakthrough therapies

Some new drugs have a "breakthrough therapy" designation,[16] which can be associated with even higher prices. The designation is given to certain drugs—those with early indications of being substantively more effective than the current clinical standard—to allow an expedited review process by the FDA. Of the 252 submitted new drug reports, 54 drug products were approved by the FDA with a breakthrough therapy designation. All of the breakthrough therapies were brand drugs, and the most common therapeutic class—representing 17 of the 54 reports—was ***Anti-Cancer Drugs***.

Though breakthrough therapy designation does not guarantee that the drug will be a true "breakthrough," the designation nonetheless tends to be associated with higher prices, even when comparing against other brand drugs. Branded drug products that did not report a breakthrough therapy designation had a median introductory price of $7,477, while those that did report a breakthrough therapy designation had a median introductory price that was more than three times higher, at $26,220.

Price growth events

In the 12 months between July 2024 and June 2025, there were over 4,100 price increases for drug products (NDCs) already on the market, and of these 716 required reporting under the Act.[17] These 716 price increases are referred to as *price growth events*, and include 684 price increases for brand drugs and only 32 for generics.[18] These price increases occurred for 625 drugs, meaning that 71 drug products had two or more significantly large price increases within a year. More than 77,000 Minnesotan residents used one of the required 716 drugs in 2024—representing more than 6% of all retail prescription drug spending. Appendix C provides summary data for these required price growth reports disaggregated by brand status, price after increase, number of years on market, and therapeutic class.

Price growth history and trends

For the 716 price growth events that required reporting under Minnesota law, MDH received 457 reports between July 2024 and June 2025, covering 437 reports for brand drugs and 20 reports for generic drugs.[19] Figure 3 displays the reported pricing history between 2020 and 2025, the five years leading up to the reporting period for this legislative report. Cumulatively, the average increase in list price for these drugs over this period

[16] Breakthrough Therapy | FDA (https://www.fda.gov/patients/fast-track-breakthrough-therapy-accelerated-approval-priority-review/breakthrough-therapy)

[17] Over this same period, there were nearly 36,000 active drug products that had no price change and around 2,000 active drug products that had a price decrease.

[18] The small number of generics is due to the higher price growth reporting threshold for generic drugs. An additional 172 generic drugs would have been required if generics had the same reporting threshold as brand drugs.

[19] The 437 reports for brand drugs represented 361 unique drug products, because many drug products had multiple reportable price increases.

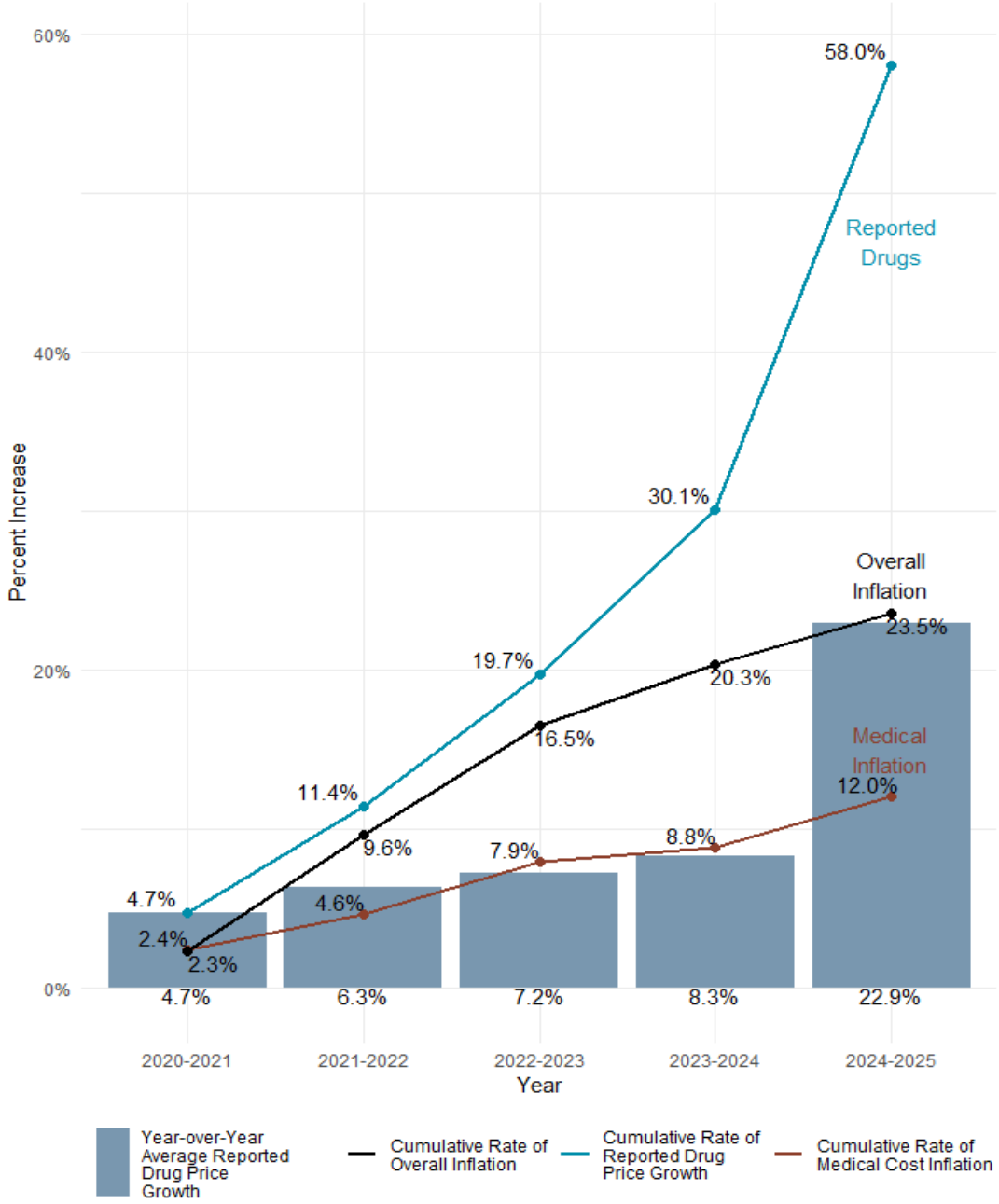
was approximately 58%, which is more than two times higher than general inflation[20] and nearly five times the cumulative rate of inflation for medical services.[21] Additionally, Figure 3 shows how the size of the year-over-year increases is growing over time, meaning that the manufacturers of these drugs have been increasing prices by a larger percent each year. The most recent year saw a particularly large jump in list prices: 22.9%.

In their reports to MDH, manufacturers most commonly identified manufacturing costs (including capital improvements), supply chain costs, market factors, research and development work, and patient value as considerations when pursuing price increases (with at least 20 manufacturers identifying each of these). Fifteen manufacturers specifically mentioned inflationary pressures and four identified current economic conditions as reasons for increasing prices. These stated reasons are self-reported, meaning MDH has no ability to audit or otherwise validate them.

[20] St. Louis Federal Reserve. Consumer Price Index for All Urban Consumers: All Items in U.S. City Average (CPIAUCSL) | FRED | St. Louis Fed (https://fred.stlouisfed.org/series/CPIAUCSL)

[21] St. Louis Federal Reserve. Consumer Price Index for All Urban Consumers: Medical Care in U.S. City Average (CPIMEDSL) | FRED | St. Louis Fed (https://fred.stlouisfed.org/series/CPIMEDSL)

Figure 3. Five-year pricing history relative to inflation for submitted price growth reports, July 2024 – June 2025[22]



Sources: MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024, to June 30, 2025; St. Louis Federal Reserve, Consumer Price Index for all Urban Consumers: Medical Care in U.S. City Average (https://fred.stlouisfed.org/series/CPIMEDSL). St. Louis Federal Reserve. Consumer Price Index for all Urban Consumers. Available at Consumer Price Index for All Urban Consumers: All Items in U.S. City Average (CPIAUCSL) | FRED | St. Louis Fed (https://fred.stlouisfed.org/series/CPIAUCSL).

[22] MDH excluded two major outliers from this analysis, which were two drugs (NDCs) that increased in price between 2023-2024 by more than 900% and again in 2024-2025 by more than 1,600%.

International prices

The U.S. prices for drugs with reported price growth events continue to outpace international prices for the same medications. Of the 457 reported price growth events, 103 brand drug products were reported as being sold internationally.[23] These drugs were between 24% cheaper in the U.S. and nearly 4,100% more expensive, with half of these drugs being more than 275% higher in the U.S. than internationally. The median markup over international prices was $258 per unit of medication (mL, gram, or capsule/tablet). See international comparisons for the most expensive reported price growth drugs in Appendix D.

Generic delay agreements

For the 457 price growth events that were reported, there were just seven with generic delay agreements. Generic delay agreements are agreements between brand and generic manufacturers where the generic manufacturer agrees to delay launch of a drug product in exchange for payment from the brand manufacturer.[24,25] They effectively delay downward pricing pressure from generic manufacturers and usually occur due to lawsuits, settlements, or patent disputes; generic delay agreements have been estimated to cost U.S. consumers an additional $3.5 billion in drug spending annually.[26]

The existence of a generic delay agreement for a drug with a significant price increase means that payers and patients are paying increasingly higher prices for drugs while lower-cost alternatives are being postponed. During this period, the seven drugs with generic delay agreements cost Minnesota payers and patients approximately $48 million in gross spending and had more than 9,000 claims. While generic manufacturers are paid for their delayed entry to the market, there is no clear benefit to payers and patients.

Net profit margins

As part of their price growth reporting, manufacturers are required to estimate their drug-specific *net profit*—meaning, assessing how much they retain in profits after accounting for expenses, including research and development, manufacturing costs, distributing costs, and marketing costs. Manufacturers often justify prescription drug price increases as necessary due to increased input expenses—indeed, about 65% of the 457 reported price growth events mentioned increased costs of manufacturing as a justification for increasing prices. These estimates are self-reported and MDH cannot validate them because this information is not otherwise available. MDH calculates the *net profit* ***margin*** by taking the reported net profit and dividing it by the reported

[23] Based on cross-checks between submitted reports and publicly available marketing information, this is likely an undercount of the number of reported drug products that are sold internationally. However, MDH has little ability to externally verify actual international sales.

[24] Pay-for-Delay: When Drug Companies Agree Not to Compete | Federal Trade Commission (https://www.ftc.gov/news-events/topics/competition-enforcement/pay-delay)

[25] Harvard Business Review. How Pharma Companies Game the System to Keep Drugs Expensive (https://hbr.org/2017/04/how-pharma-companies-game-the-system-to-keep-drugs-expensive)

[26] Federal Trade Commission. Pay-for Delay FTC Study (https:/www.ftc.gov/sites/default/files/documents/reports/pay-delay-how-drug-company-pay-offs-cost-consumers-billions-federal-trade-commission-staff-study/100112payfordelayrpt.pdf)

net revenue. This identifies what proportion of total revenues are retained as profit. A higher profit margin indicates that more revenue is retained as profit and less revenue is going toward business costs.

Table 2 shows the average reported net profit margins by the type of drug. The average net profit margin for price growth events submitted between July 2024 and June 2025 ranged from 13% for brand biologic drugs to 29% for generic small molecule drugs. This suggests that these drugs—which are increasing rapidly in price—are also profit drivers for manufacturers. Based on the calculated profit margins, MDH estimates that nearly $90 million of gross spending[27] on reported price growth drugs went directly to manufacturers' profits, corresponding to an overall average net profit margin of 22%. More than $2.5 million came directly from patient cost sharing.

Table 2. Average reported net profit margins and costs to Minnesota payers and patients by type of drug, July 2024 – June 2025[28]

Drug type	Number of submitted reports[29]	Average reported net profit margin	Total estimated net profit paid by Minnesota payers and patients	Total estimated net profit paid by Minnesota patients
Brand biologics	97	13%	$35,096,255	$1,208,554
Brand small molecule drugs	278	24%	$54,026,206	$1,467,070
Generic small molecule drugs	20	29%	$341,237	$27,443
Total	**395**	**22%**	**$89,463,699**	**$2,703,067**

Sources: MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024 to June 30, 2025. Minnesota Department of Health, Minnesota All Payer Claims Database (https://www.health.state.mn.us/data/apcd/index.html)

Average reported net profit margins varied significantly by therapeutic class. Antidepressants, miscellaneous cardiovascular agents, and anti-cancer drugs all have net profit margins exceeding 20% (see Table 3). This means that more than one-fifth of revenue on these drugs was retained as profit by manufacturers—and in the case of antidepressants with price growth, $63 of every $100 was kept as profit.

As many people in Minnesota struggle to afford life-saving and live-improving medications, and as prices for many drugs are increasing well above the rate of inflation, these net profit margin data provide helpful context. These data are aggregated, unverified, and are only one piece of a complex puzzle. Nevertheless, this

[27] Claims payment data reported to the Minnesota All Payer Claims Database (MN APCD) is provided before rebates. Because many of these are brand drugs, it is likely that the total amount paid by payers (health insurers and PBMs) is less than the gross figure due to rebate agreements between manufacturers and payers.

[28] Net profit margins are calculated by dividing net profit by total revenue. Entities report each of these values to MDH for each drug product (NDC). Estimated net profit is calculated by multiplying the net profit margin by the total cost of claims for each drug. Data quality concerns and submission noncompliance resulted in the omission of 62 submitted price growth reports for this analysis.

[29] Fewer total reports are analyzed in this section (395) than the total submitted (457). Thirty reports were censored due to data quality issues in the fields underlying this analysis. The remaining 32 removed reports were reports of NDCs that experienced multiple reportable pricing events within the year—these were removed because MDH was interested in the manufacturers' financial position on a per-NDC basis rather than a per-event basis.

transparency data helps payers in Minnesota gain a better understanding of where their payments are going and indicates that a notable portion of prescription drug price increases are supporting manufacturer profits.

Types of drugs with price growth

To illustrate the kinds of drugs where the impacts of pharmaceutical price increases are most significant, Table 3 displays the top 10 therapeutic classes by total gross spending for the 716 price growth events that triggered reporting by Minnesota law. The top three therapeutic classes by total spending were ***Anti-Inflammatory Pain Relievers***, ***Dermatologicals*** (drugs for skin conditions), and ***Anti-Cancer Drugs***—the same top three as last year, per the 2025 Prescription Drug Price Transparency Legislative Report (PDF).

Key findings related to Table 3:

Drugs with reportable price increases made up 31% of all spending in the ***Anti-Inflammatory Pain Relievers*** therapeutic class during calendar year 2024, which amounted to more than $264 million of total gross spending, with more than $13 million paid directly from Minnesotan residents' pockets. This class of pain reliever drugs has been the costliest of all therapeutic classes for the last three periods of data collection (see Figure 4), which means that these drugs on which payers and patients are already spending hundreds of millions of dollars are continuing to increase rapidly in price.

- Five etanercept drug products (brand-name Enbrel) were responsible for $155 million—or about 60%—of the spending in this class, and four of the five Enbrel drug products had *two* reportable price increases during the reporting period.
- The other three drug families in this class included apremilast (Otezla) and upadacitinib (Rinvoq), both of which cost payers and patients about $50 million, and canakinumab (Ilaris), which accounted for about $5 million in spending.

Nearly $150 million was spent on drugs for skin conditions (***Dermatologicals***) that experienced significant price growth. The primary cost drivers in this class were risankizumab-rzaa (Skyrizi), tralokinumab-ldrm (Adbry), and bimekizumab-bkzx (Bimzelx).

- Skyrizi was by far the costliest drug in this therapeutic class, with more than $135 million spent in total and more than $5 million coming from direct patient cost-sharing. Skyrizi has had required price growth reports for three years in a row.
- ***Dermatologicals*** have been the second-costliest therapeutic class of price growth for three of the four periods, driven by Skyrizi and secukinumab (Cosentyx), the latter of which did not have a required price growth report for the first time this year.

The third costliest therapeutic class for price growth drugs was ***Anti-Cancer Drugs***, with $63 million in retail pharmacy spending.[30] The 57 drug products that required reporting represented 30 different drug families that treat more than a dozen different types of cancer.

- Of these 30 drug families, 25 had orphan drug designations.[31] An orphan drug designation is assigned to a drug product when it treats a rare disease, and qualifies manufacturers of the drug for tax credits, fee

[30] Reportable price growth drugs in this class include several physician-administered drugs that are typically billed through the medical benefit and therefore will not appear in Table 3 or Figure 4.

[31] Determined by searching for the drug on Search Orphan Drug Designations and Approvals (https://www.accessdata.fda.gov/scripts/opdlisting/oopd/index.cfm). Accessed 11/12/2025.

exemptions, and extended market exclusivity after drug approval.[32] As a result, this designation increases potential revenue by giving the manufacturer a longer period of monopoly before generic competition can enter the market. And their appearance on this list means these drugs have increased in price by a large margin over the last year or two.

- On average, price growth drugs in the ***Anti-Cancer Drugs*** therapeutic had a reported net profit margin of 29%, meaning that for every $100 in revenue, $29 was retained as profit.

Table 3. Top 10 therapeutic classes by gross total spending for price growth events, July 2024 – June 2025

Therapeutic class	Number of unique drugs (NDCs)* with price growth events	Number of price growth events*	Average reported net profit margin	Number of claims	Total paid	Patient paid	Share of all spending in class spent on drugs with price growth events
Anti-Inflammatory Pain Relievers	18	29	9%	36,557	$264,342,197	$13,469,961	31%
Dermatologicals	13	13	11%	9,225	$143,017,066	$5,695,860	16%
Anti-Cancer Drugs	57	62	29%	4,485	$63,718,975	$1,843,183	7%
Hematopoietic Agents	13	14	2%	1,616	$24,246,162	$620,543	63%
Miscellaneous Cardiovascular Agents	7	10	41%	889	$22,181,419	$323,542	8%
Miscellaneous Metabolic Agents	28	43	20%	1,518	$19,124,576	$724,834	10%
Vaccines	5	8	19%	83,792	$17,347,270	$54,309	12%
Antidepressants	20	20	63%	1,804	$5,900,952	$330,657	4%
Antimyasthenic and Cholinergic Agents	3	3	--[†]	124	$5,525,876	$46,625	86%
Neuromuscular Agents	1	1	82%	121	$4,963,105	$20,363	11%

* Where the number of price growth events is larger than the number of unique drugs (NDCs), one drug had multiple price growth events between July 2024 and June 2025 that required reporting. That is, the manufacturer increased the price beyond the reporting threshold twice or more in the same year.

[†] Excluded due to a combination of failure to report and data quality concerns.

Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information at Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span); MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024 to June 30, 2025. Minnesota Department of Health, Minnesota All Payer Claims Database (https://www.health.state.mn.us/data/apcd/index.html).

[32] Designating an Orphan Product: Drugs and Biological Products | FDA (https://www.fda.gov/industry/medical-products-rare-diseases-and-conditions/designating-orphan-product-drugs-and-biological-products)

Trends in types of price growth drugs

Figure 4 displays the top ten therapeutic classes by gross total spending since January 2022.[33] By looking at the relative ranks of therapeutic classes over time, it shows trends in areas of pharmaceutical medicine where costs are high, and prices are still increasing.

For the last three periods, the top three therapeutic classes by cost to payers and patients have been the same: ***Anti-Inflammatory Pain Relievers***, ***Dermatologicals*** (drugs for skin conditions), and ***Anti-Cancer Drugs***.

Additional findings related to Figure 4:

- Price growth drugs for heart failure and pulmonary arterial hypertension drove spending in the ***Miscellaneous Cardiovascular Agents*** class, including sacubitril-valsartan (Entresto)—a drug that was part of the first year of Medicare drug negotiations in 2023. Other key drivers were ivabradine (Corlanor) and treprostinil (Orenitram), both of which are designated as orphan drugs.
- Spending in the ***Hematopoietic Agents*** class was dominated by drugs for chronic immune thrombocytopenia, a rare blood clotting disorder. By far the costliest of these drugs was eltrombopag olamine (Promacta), which stimulates platelet production—a drug that was approved as an orphan drug and has been on the market for more than 15 years. [34]
- ***Miscellaneous Metabolic Agents*** is a broad class of hormone-altering drugs that treat a variety of conditions:
  - Pasireotide (Signifor) and osilodrostat (Isturisa) are new therapies produced by the same manufacturer for treatment of Cushing Syndrome, and have had seven and five required price growth reports *per drug product (NDC),* respectively, since MDH started collecting information on price growth. [35]
  - Several drugs for osteoporosis have had required price growth reports since 2022: branded denosumab (Prolia), abaloparatide (Tymlos), and romosozumab-aqqg (Evenity)
  - Other drugs that have been cost drivers for this therapeutic class include leuprolide acetate (Lupron Depot) for central precocious puberty, elagolix (Orilissa) for endometriosis, and tolvaptan (Jynarque) for polycystic kidney disease.
- In the last year of data, the average reported net profit margin for drugs in the ***Antidepressants*** therapeutic class—a class that has hovered around the top 15 since 2022—was 63%, or $63 for every

[33] Note that for this figure only, total spending for the most recent reporting period (July 2024 to June 2025) uses only claims from June 2024 to December 2024. The version of the MN APCD at the time of publication had claims only through December 2024. All other analyses in this report use the full 2024 calendar year of claims—including Table 2, which results in the slightly different rankings of some therapeutic classes.

[34] Voxeletor (Oxbryta), a drug in the *Hematopoietic Agents* class that is used for treating sickle-cell disease, has had several price growth reports but was voluntarily withdrawn after recalls by the FDA: FDA is alerting patients and health care professionals about the voluntary withdrawal of Oxbryta from the market due to safety concerns | FDA (https://www.fda.gov/drugs/drug-safety-and-availability/fda-alerting-patients-and-health-care-professionals-about-voluntary-withdrawal-oxbryta-market-due)

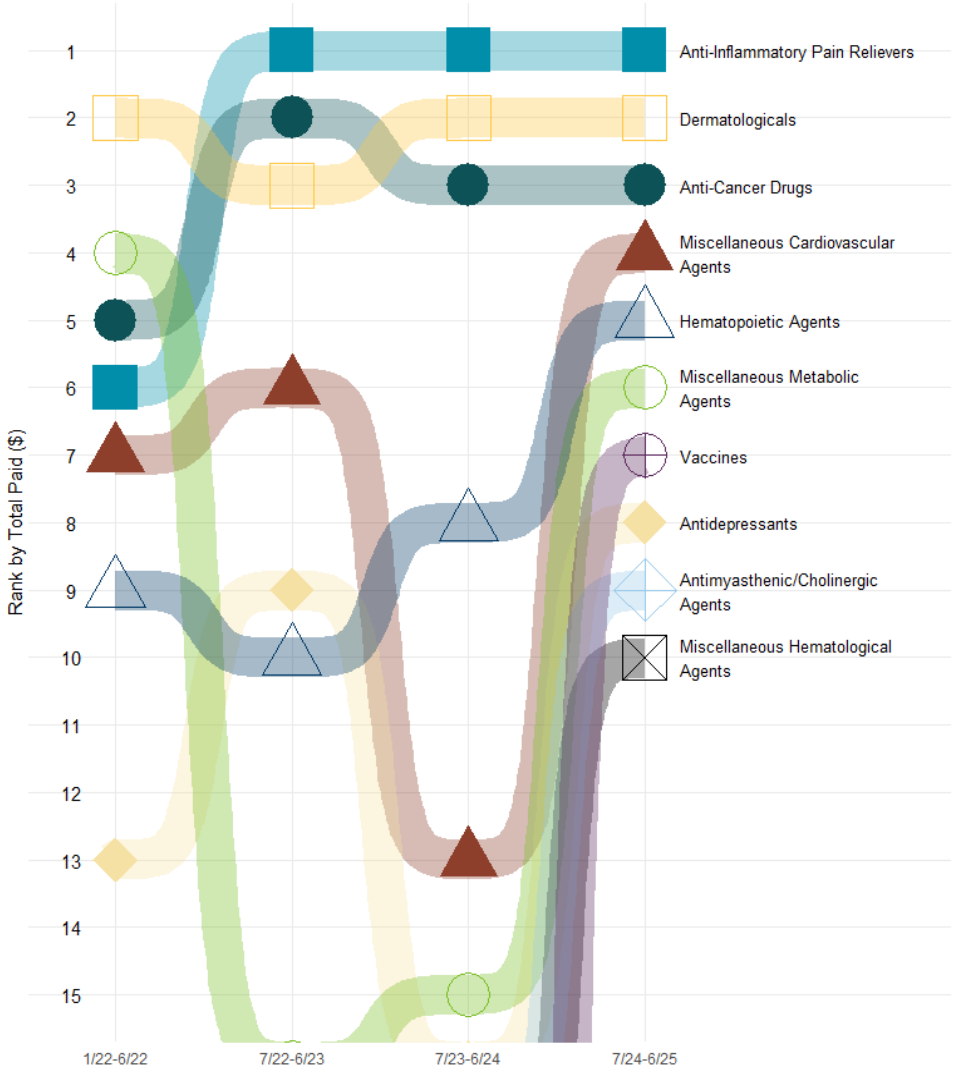
[35] Drug products for pasireotide pamoate have had seven required price growth reports; an analog drug, pasireotide diaspartate (also produced by Recordati Rare Diseases) has had six required price growth reports.

$100 of gross revenue (see Table 3). This high profit margin is particularly notable given that many of the key drivers of spending are brand drugs that have been on the market for more than a decade.[36]

- The relative cost of ***Antimyasthenic and Cholinergic Agents*** drugs has increased gradually from 19th (7/22-6/23) to ninth (7/24-6/25). This increase is entirely due to continued price increases for the drug amifampridine (Firdapse), which treats a rare disease called Lambert-Eaton Myasthenic Syndrome.

[36] These include Wellbutrin (generic: bupropion HCl), Fetzima (generic: levomilnacipran), Viibryd (generic: vilazodone), and Zelapar (generic: selegiline).

Figure 4. Top 10 therapeutic classes of required price growth reports by gross MN APCD spending, July 2024 – June 2025, and relative rank since January 2022[37, 38]



Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information at Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span); MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of January 1, 2022 to June 30, 2025. Minnesota Department of Health, Minnesota All Payer Claims Database (https://www.health.state.mn.us/data/apcd/index.html).

[37] For this figure, the top ten most costly therapeutic classes of price growth drugs between July 2024 and June 2025 are based on claims between July 2024 and December 2024. All other price growth analyses in this report use a full year of claims (calendar year 2024).

[38] The following therapeutic classes were in the top 10 for other time periods. 1/22-6/22: 1—Antidiabetics, 3—Miscellaneous Neurological Agents, 8—Miscellaneous Anti-Infective Agents, 10—Anticonvulsants; 7/22-6/23: 4—ADHD and Anti-Obesity Agents, 5—Miscellaneous Neurological Agents, 7—Digestive Aids, 8—Miscellaneous Gastrointestinal Agents; 7/23-6/24: 4—Antipsychotics, 5—Digestive Aids, 6—Antihyperlipidemics (cholesterol-lowering drugs), 7—Migraine Products, 9—Miscellaneous Gastrointestinal Agents, 10—Antihistamines. Note that these rankings may be slightly different than in previous legislative reports due to updated claims data in the MN APCD.

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Impact assessment

As a part of its annual legislative report, MDH must assess the Act's effectiveness in addressing three primary goals identified in statute:

- Promoting transparency in pharmaceutical pricing for the state and other payers.
- Enhancing the understanding of pharmaceutical spending trends.
- Assisting the state and other payers in the management of pharmaceutical costs.

This section provides MDH's assessment of the Act's effectiveness toward each of the statutory goals.

Perhaps most visibly, the Act brings transparency on drug prices for some of the most important prescription drugs to Minnesota residents. Transparency data are available to everyone—including the Minnesota residents who filled one or more of the 1.3 million prescriptions for at least one of the drugs with required new drug or price growth reporting. Data is available for drugs that treat rare diseases, drugs with few therapeutic alternatives, and drugs that have transformed care for autoimmune disorders.

Prior to the Act, Minnesota residents only learned of price increases at the pharmacy counter. Now the Act enables the tracking and sharing of timely online information to the public through this report and data dashboards available on the RxPT Data & Dashboards[39] webpage, which payers can consider when building formularies and contracting with PBMs. Patients, advocates, payers, and other stakeholders in 2025 made over 31,500 visits to the price transparency web pages.

In addition, the Act helps identify emerging patterns in pharmaceutical spending and provides insights into the impact of supply chain participants on drug spending that enhances understanding of pharmaceutical spending. MDH's analysis of transparency data found the following:

- The average price increase among drugs with quickly growing list prices spiked in the latest year of reporting: the cumulative five-year price increase among drugs reported in this period was 58%, up from 37% the year prior. This rate of increase is more than double the rate of overall inflation in the U.S.
- Three therapeutic classes have remained the most costly of the required price growth reports in Minnesota for three years in a row: *Anti-Inflammatory Pain Relievers*, *Dermatologicals* (drugs for skin conditions), and *Anti-Cancer Drugs*. This combination—consistently high total claims spending and quickly increasing prices—suggests that drugs in these therapeutic areas may continue to present affordability challenges for patients, insurers, and other health care payers.
- Analysis of new-to-market drugs sheds light on market power at launch and identifies emerging areas of high prescription drug spending. Anti-cancer drugs were the most common therapeutic class of drug with high enough prices to require reporting to MDH in three of the four years of reporting.
- Manufacturers of price growth drugs reported an average profit margin of 22%—which corresponds to nearly $90 million of gross drug spending on claims that went directly to profits.

In sum, the Act produces data that brings needed visibility to the profits and financial burden associated with certain high cost drugs and offers another tool patients, health insurers, and policy makers can use to manage prescription drug spending. Health plans, employers, and Minnesota residents continue to call increasing attention to the financial strain and sacrifices associated with paying for prescription drugs. MDH has aimed to

[39] RxPT Data & Dashboards (https://www.health.state.mn.us/data/rxtransparency/research/dashboards/index.html)

help identify market dynamics that contribute to high drug spending like those the Federal Trade Commission (FTC) characterized as "growing profit centers for vertically integrated pharmacy benefit managers" (FTC Specialty Generic Drugs, January 2025 (PDF).[40] The Act's transparency data can help policy makers identify policy options to increase affordability and help health care payers to identify possible opportunities to reduce spending on prescription drugs. One example of this is MDH's provision of prescription drug price transparency data, as well as technical assistance, to the Minnesota Prescription Drug Affordability Board (MN PDAB) to inform the Board's work to conduct drug cost reviews and set payment limits.[41]

Individuals may submit their recommendations on drugs MDH should consider for future Drugs of Substantial Public Interest lists through MDH's online public input form (Public Input on Prescription Drug Price Transparency at MDH).[42] MDH is excited to further invest in 2026 into engaging stakeholders to identify their data needs and how the Act can further support them in managing prescription drug spending.

Conclusion

The Minnesota Legislature passed the Act in response to concern with high and quickly increasing prescription drug prices amidst limited transparency into what drives drug prices. The Prescription Drug Price Transparency Act continues to provide transparency data on high drug costs and insights into the prescription drug market as health care affordability in general—and pharmaceuticals in particular—is becoming increasingly challenging. This transparency and associated analysis will help identify select policy options for policy makers to increase affordability. Since the Act's inception, MDH has identified thousands of price increases faced by Minnesota residents and health care payers, as well as hundreds of new drug introductions. Through this, MDH has made tremendous progress with drug price transparency, pulling back the veil of secrecy obscuring prices and spending drivers.

While transparency is a starting point, meaningful efforts to drive down drug prices will require a multi-pronged approach via implementation of new policies and market regulation that supports health care payers in managing prescription drug spending. Much of the responsibility for oversight of these issues lies with Congress or the federal government. In Minnesota, the Act's drug price transparency is enhanced by new work on drugs of substantial public interest, which takes a comprehensive view of the prescription drug supply chain. The state has also established a Prescription Drug Affordability Board, which has the authority to set upper payment limits. Most states, including Minnesota, now license PBMs—and some have begun requiring that PBMs have a fiduciary duty to their health plan clients. States have also sought to improve access to medicines through regulating the use of prior authorization and step therapy, as well as through supporting small and independent pharmacies. The Act is one of many tools needed for patients, health insurers, and policy makers to understand the prescription drug market and manage prescription drug spending.

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[40] FTC Specialty Generic Drugs, January 2025 (https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf)

[41] MN Department of Commerce, Minnesota's Prescription Drug Affordability Board (https://mn.gov/commerce/insurance/health/pharmacy-drug-affordability-board/).

[42] Public Input on Prescription Drug Price Transparency at MDH (https://forms.office.com/Pages/ResponsePage.aspx?id=RrAU68QkGUWPJricIVmCjJEFDds2GihEt42OkgoSyU1URFFVTE1VWFlFQ1JIMVVRQ09CUkdBWUpTOS4u)

MDH looks forward to continuing to work with the legislature and stakeholders on strengthening this initiative and supporting ideas for making prescription drugs more affordable for patients and spending on prescription drugs sustainable.

Appendix A: Glossary

Brand Drug – means a Prescription Drug that is produced or distributed pursuant to: (1) a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or (2) a biologics license application approved under United States Code, title 42, section 262(a)(c).

Drug – under the Act, reporting on drugs occurs at the dug product level, which is identified using National Drug Codes (NDCs). This is the most granular level of tracking drugs in the United States.

Drug Product Family/Drug Family – a group of one or more prescription drugs that share a unique generic drug description (non-trade name).

Exclusivity Period – a period of time after a drug is approved by the Food and Drug Administration (FDA) during which competitor drugs are delayed or prohibited from being approved by the FDA.

Generic Drug – means a Prescription Drug that is marketed or distributed pursuant to: (1) an abbreviated new drug application approved under United States Code, title 21, section 355(j); (2) an authorized generic as defined under Code of Federal Regulations, title 42, section 447.502; or (3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

National Drug Code (NDC) – a code maintained by the federal Food and Drug Administration that is uniquely assigned by manufacturer, product, and packaging.

Price – price under the Act refers to the wholesale acquisition cost (WAC) of a drug, which is the list price set by the drug manufacturer. The price of a drug is rarely the same as what is ultimately paid by patients and health insurance plans.

Pricing Event – a pricing event is when a drug changes price, including new drug events and price growth events. It could be setting the initial price upon introduction to the market (*new drug event*), or it could be a price increase or decrease of an existing drug (*price growth event*). Reporting under the Act is often determined based on pricing events (for new drug and price growth report types). Pricing events are tied to specific drug products (NDCs) and dates.

- **New drug event**: the act of a drug manufacturer introducing a new drug product (NDC) to the market in the United States at a price that exceeds the statutory threshold under the Act.
- **Price growth event**: the act of a drug manufacturer increasing the price of a drug product (NDC) already on the market significantly enough that it meets the statutory thresholds under the Act. It is possible for a single drug product to have multiple price growth events within a year.

Rebate – a discount, chargeback, or other price concession that affects the price of a prescription drug product.

Report – A report is a submission to MDH by reporting entities including statutorily required data elements—these are primarily focused on drug financial information—for a single drug product. Each new drug and price growth pricing event that meets the statutory thresholds requires a report. And each drug on the public interest lists requires a report from each eligible reporting entity. Entities may submit multiple reports simultaneously.

- **Required report**: reports for drugs and pricing events that are required under the Act.
- **Submitted report**: reports submitted to MDH for required reports

Therapeutic Class – a group of drugs used for the treatment, remediation, or cure of a specific disorder or disease.

Wholesale Acquisition Cost (WAC) – a manufacturer's published list price for sale of a prescription drug product with a unique NDC to a wholesale drug distributor or other entity that purchases a prescription drug directly from the manufacturer, not including any price concessions.

Appendix B: Program Operations and Data Sources

Program operations

MDH ensures the transparency data and associated analysis are accurate and meaningfully responsive to the concerns of Minnesota residents through various efforts. Here are examples of how MDH connects with the public and reporting entities:

- MDH has over **2,300 registered reporting entities**—drug manufacturers, wholesalers, PBMs, pharmacies, and third-party associates—that are submitting data.
- MDH also receives **public input** submissions via an online form (Public Input on Prescription Drug Price Transparency at MDH) that allows members of the public to share their experiences with paying for prescription drugs or to make suggestions on specific drugs, pricing strategies, or industry practices that MDH should investigate through transparency reporting and analysis.
- To address data quality issues, MDH **contacted more than 900 reporting entities** in 2025 and provided practical reporting guidance that resulted in improved data submissions.
- MDH maintains **up-to-date guidance** that is responsive to reporting entities and the public through Transparency Reporting Resources[43] like the Frequently Asked Questions for RxPT Reporting (PDF)[44] document, which was last updated in November 2025.

MDH also maintains a wide network of industry and policy experts, state and federal officials, health plans, employer groups, pharmacists, and others with knowledge of the pharmaceutical supply chain. In 2025, MDH regularly got feedback from leading experts and stakeholders in Minnesota —this and future analysis will help provide health plans and others with data on industry practices that would not otherwise be accessible.

Data collected under the Act

MDH collects three different types of data under provisions of the Act, which are summarized in Table B1.

[43] Transparency Reporting Resources (https://www.health.state.mn.us/data/rxtransparency/resources/index.html)

[44] Frequently Asked Questions for RxPT Reporting (https://www.health.state.mn.us/data/rxtransparency/docs/rxptfaq.pdf)

Table B1: Data collected under the Prescription Drug Price Transparency Act

Reporting Type	When reporting is required	Reporting entities	Cadence
New drug	Any time a manufacturer introduces a new drug for sale that is over a certain threshold* for a 30-day supply or course of treatment, and, if a generic or biosimilar, is within 15% of the referent brand name drug.	Manufacturers	Ongoing: manufacturers have 60 days to report after an eligible new drug introduction.
Price growth	Any time a manufacturer increases the price of an existing drug over certain percentage thresholds** set in statute for a 30-day supply or course of treatment.	Manufacturers	Ongoing: manufacturers have 60 days to report after an eligible price increase.
Public interest	When MDH publishes a list of up to 500 drugs.	Manufacturers Wholesalers PBMs Pharmacies	Quarterly: MDH publishes lists, sends entities a notification 30 or more days later, and then entities have 60 days to report.

* This threshold is the Medicare Part D Specialty Drug Threshold per Minnesota Statute 62J.84.4 (https://www.revisor.mn.gov/statutes/cite/62J.84#stat.62J.84.4). It was $950 starting in 2024. (Centers for Medicare and Medicaid Services. Contract Year 2026 Final Part D Bidding Instructions. April 1, 2025)

** For brand drugs, the threshold is 10% in the past 12 months or 16% in the past 24 months; for generics the threshold is 50% in the past 12 months per Minnesota Statute 62J.84.4 (https://www.revisor.mn.gov/statutes/cite/62J.84#stat.62J.84.4).

Supporting data

To support the analysis and identify what reporting is required, MDH used a range of reference data—including Wolters Kluwer's Medi-Span[45] and the Federal Food and Drug Administration's (FDA)[46] National Drug Code Directory[47] and Purple Book.[48] This information supports MDH's ability to analyze market characteristics and pricing trends.

MDH utilized health insurance pharmacy claims data for calendar year 2024 from the Minnesota All Payer Claims Database (MN APCD) in the analyses.[49] These data provide important context for the impact of drug prices in Minnesota by providing the most comprehensive view of health care spending in Minnesota on these drugs, but they also have some limitations to note:

- Pharmacy claims are for prescription drugs distributed through retail pharmacies and are typically processed through the pharmacy benefit of health insurance, which are tracked separately from drugs administered as

[45] Additional information about Medi-Span at Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span).

[46] The FDA is the body of the federal government tasked with ensuring the safety, efficacy, and security of various products, including food, drugs, medical devices, and more.

[47] U.S. Federal Food and Drug Administration. U.S. FDA - National Drug Code Directory (https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory).

[48] U.S. Federal Food and Drug Administration. U.S. FDA - Purple Book: Database of Licensed Biological Products (https://purplebooksearch.fda.gov/downloads).

[49] Minnesota All Payer Claims Database - MN Dept. of Health (https://www.health.state.mn.us/data/apcd/index.html)

part of onsite care and processed through medical benefits. Claims analyses in this report do not include any medical claims for prescription drugs.

- The MN APCD is periodically updated as new claims data are available. This report includes claims through December 2024, which was the most up-to-date data available at the time of analysis.
- Claims in this analysis include Minnesota Health Care Programs claims, Medicare Part C claims, and commercial reports covering mostly the fully insured market. Claims do not include Medicare Part D (due to a lag in the data) nor most data from self-insured plans.

As such, the claims data do not include all expected claims, and findings should be considered an underestimate and directional.

Appendix C: Price growth distributions

Table C1 presents summary descriptions of all drugs that met price growth reporting requirements from July 2024 to June 2025—it includes data for drugs with and without submitted reports. Across different categorizations of drug prices and price increases, this table presents the **median**—a measure of the center of a set of values that identifies the value at which half of the values are above, and half are below—and **interquartile range** (IQR)—another measure of center that identifies the middle 50% of all values in a dataset. To learn more about the drugs described in this table, please visit MDH's Prescription Drug Price Transparency Data and Dashboards.

Table C1. Price growth distributions based on Medi-Span data, July 2024 – June 2025

	Drug (NDC) count	Median after increase	IQR* after increase	Median current increase	IQR* current increase	Median 12-month increase	IQR* 12-month increase	Median 24-month increase	IQR* 24-month increase
Brand Status									
Brand	684	$985.00	$352.09 - $3,940.28	9.9%	6.0% - 12.1%	11.3%	10.0% - 21.7%	21.3%	18.4% - 30.0%
Generic	32	$411.04	$273.14 - $547.70	93.6%	54.0% - 143.7%	108.7%	78.2% - 143.7%	109.0%	80.7% - 143.7%
Years on Market									
<= 5 Years	348	$630.72	$352.09 - $3,410.41	10.0%	8.5% - 23.2%	12.1%	10.0% - 25.0%	22.5%	20.9% - 30.6%
6 - 10 Years	146	$1,900.75	$433.20 - $7,779.79	8.0%	5.0% - 9.9%	10.8%	9.0% - 16.4%	19.5%	16.6% - 26.7%
11 - 15 Years	44	$1,849.68	$601.62 - $4,454.40	8.5%	5.0% - 9.9%	9.7%	8.0% - 12.5%	19.8%	16.6% - 20.8%
16 - 20 Years	42	$2,045.16	$827.48 - $4,220.76	5.5%	5.0% - 9.4%	10.3%	9.9% - 12.4%	17.6%	10.7% - 20.8%
Over 20 Years	136	$675.26	$204.68 - $1,301.60	10.0%	8.0% - 20.1%	21.0%	10.3% - 70.7%	46.4%	20.3% - 88.9%
WAC Range									
<= $500.00	245	$310.67	$204.40 - $352.09	10.2%	9.9% - 25.4%	20.4%	10.2% - 38.0%	23.2%	20.9% - 46.4%
$500.01 - $1700.00	185	$818.00	$603.00 - $1,054.08	10.0%	8.0% - 15.0%	10.3%	10.0% - 21.0%	21.1%	19.7% - 26.4%
>= $1700.01	286	$6,208.78	$2,430.09 - $19,067.69	7.0%	5.0% - 9.9%	10.3%	9.0% - 17.9%	20.8%	16.6% - 31.3%
Top Therapeutic Classes (by number of pricing events)									
Allergenic Extracts	170	$517.00	$352.09 - $985	13.8%	10.1% - 25.4%	13.8%	10.1% - 25.4%	23.2%	21.2% - 25.6%

	Drug (NDC) count	Median after increase	IQR* after increase	Median current increase	IQR* current increase	Median 12-month increase	IQR* 12-month increase	Median 24-month increase	IQR* 24-month increase
Anti-Cancer Drugs	62	$11,291.61	$2,789.81 - $25,500.10	8.0%	6.0% - 8.0%	9.0%	8.0% - 12.6%	18.8%	16.6% - 22.1%
Miscellaneous Metabolic Classes	43	$20,021.07	$11,555.86 - $20,159.75	5.0%	5.0% - 9.2%	14.4%	10.1% - 20.1%	30.6%	19.9% - 31.8%
Nutritional Minerals & Electrolytes	39	$237.60	$154.32 - $621.90	16.2%	9.4% - 60.7%	21.0%	9.7% - 66.5%	38.0%	19.5% - 70.5%
Nutrients	30	$196.78	$173.19 - $256.41	13.8%	10.0% - 38.7%	25.6%	16.4% - 38.7%	38.0%	20.8% - 57.5%
Anit-Inflammatory Pain Relievers	29	$5,323.70	$2,039.40 - $7,623.92	7.0%	3.0% - 7.0%	10.2%	8.2% - 10.2%	16.2%	15.7% - 16.2%
Antihypertensives	21	$400.13	$320.83 - $504.95	10.0%	9.0% - 10.0%	10.0%	10.0% - 10.0%	20.9%	20.9% - 20.9%
Antidepressants	20	$330.24	$301.12 - $2,252.23	9.9%	9.9% - 9.9%	9.9%	9.9% - 10.2%	20.8%	19.2% - 26.7%
Opioid Pain Relievers	17	$1,417.98	$638.78 - $1,896.18	15.0%	10.0% - 15.0%	15.0%	15.0% - 21.0%	29.6%	24.2% - 46.4%
Anticonvulsants	16	$1,296.56	$323.85 - $2,566.11	7.0%	5.0% - 19.5%	12.4%	10.3% - 51.2%	31.3%	27.9% - 51.2%

*IQR stands for inter-quartile range, which is the range that encompasses the middle 50% of values. 25% of values are above the range, and 25% of values are below the range.

Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information at Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span). MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024, to June 30, 2025.

Appendix D: Most expensive price growth drugs & foreign price comparisons

Table D1 presents data on the most expensive drug families that required reporting for a price increase—including the average list price, net profit margin, total spending, and number of patients in Minnesota.

Figure D1 presents the average prices of reported drugs alongside the average price in foreign markets, among the most expensive price growth drug families with reported foreign prices.

To learn more about the drug families described in this table and to assess the competitiveness within each of these drug families, please visit MDH's Prescription Drug Price Transparency Data and Dashboards web page.

Table D1. Top 25 most expensive drug families with price growth events, July 2024 – June 2025

Rank	Drug Product Family	Brand name	Condition(s) treated	Average price (WAC) per unit	Unit of measure	Average reported net profit margin	Total paid in claims*	Average cost per claim*	Number of MN patients*
1	Lisocabtagene Maraleucel	Breyanzi	Cancer	$531,350	EA	17.2%	--	--	--
2	Omidubicel-onlv	Omisirge	Cancer	$512,070	EA	--†	--	--	--
3	Axicabtagene Ciloleucel	Yescarta	Cancer	$503,580	EA	47.3%	--	--	--
4	Autologous Cultured Chondrocytes on Collagen Membrane	MACI	Knee Cartilage Defects	$63,244	EA	5.3%	--	--	--
5	Risankizumab-rzaa	Skyrizi	Plaque Psoriasis, Psoriatic Arthritis	$22,383	ML	53.4%	$135,366,076	$20,948	2,148
6	Triptorelin Pamoate (CPP)	Triptodur	Central Precocious Puberty	$22,298	EA	48.2%	$1,614,797	$19,936	43
7	Canakinumab	Ilaris	Periodic Fever Syndromes, Juvenile Idiopathic Arthritis	$19,833	ML	16.5%	$5,124,706	$25,624	37
8	Pasireotide Pamoate	Signifor LAR	Cushing Syndrome, Acromegaly	$19,544	EA	14.4%	$1,049,316	$22,811	<11
9	Teprotumumab-trbw	Tepezza	Thyroid Eye Disease	$18,019	EA	7.9%	$410,546	$45,616	<11
10	Brentuximab Vedotin	Adcetris	Cancer	$12,200	EA	1.2%	--	--	--
11	Risankizumab-rzaa (Crohn's)	Skyrizi	Crohn's, Ulcerative Colitis	$9,832	ML	53.4%	$1,644,066	$19,808	30

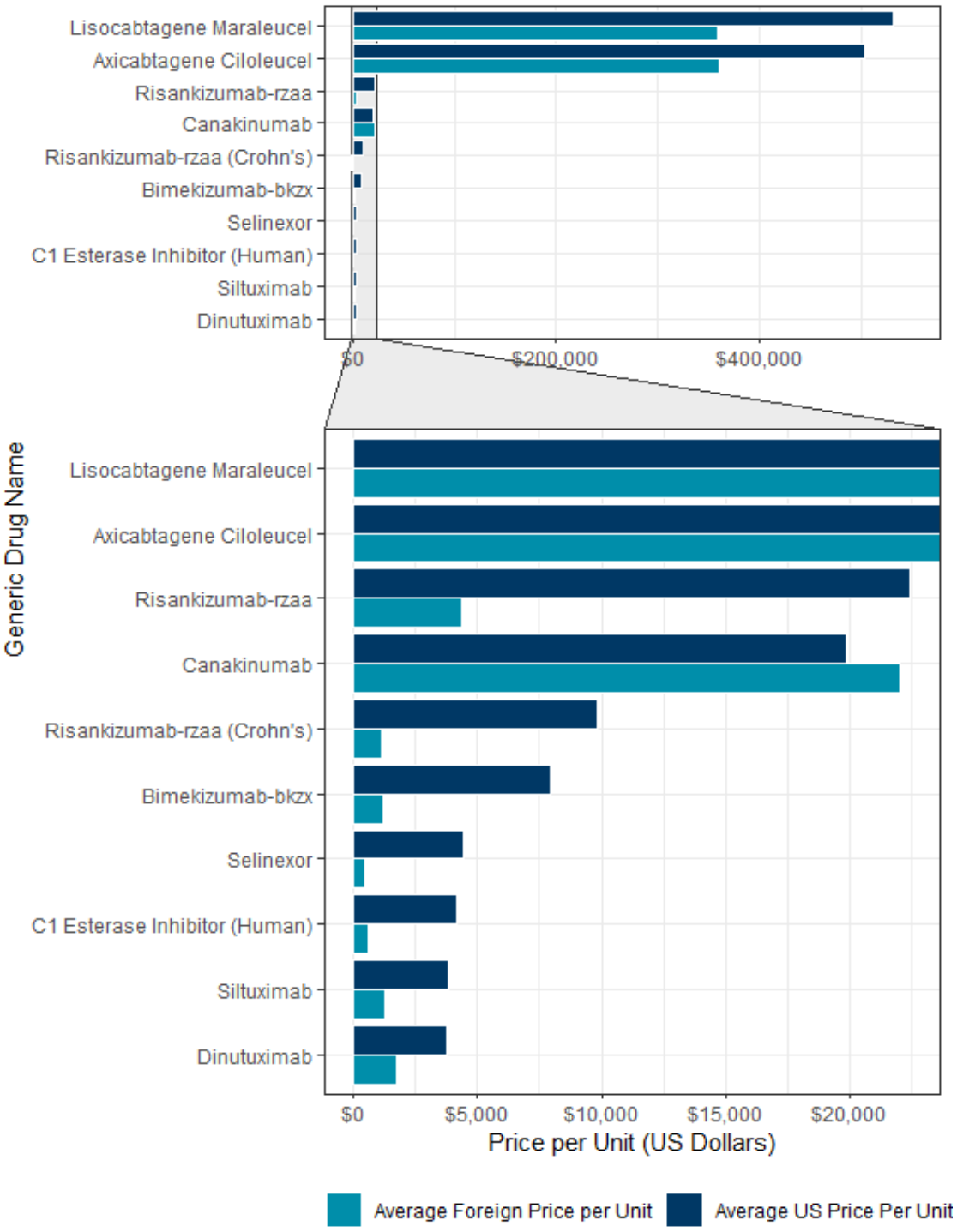
Rank	Drug Product Family	Brand name	Condition(s) treated	Average price (WAC) per unit	Unit of measure	Average reported net profit margin	Total paid in claims*	Average cost per claim*	Number of MN patients*
12	Ropeginterferon alfa-2b-njft	Besremi	Cancer	$9,056	ML	21.5%	$4,056,573	$14,805	33
13	Antivenin Micrurus Fulvius	Antivenin Micrurus Fulvius	Snake Bites	$8,010	EA	7.8%	--	--	--
14	Bimekizumab-bkzx	Bimzelx	Plaque Psoriasis, Psoriatic Arthritis	$7,923	ML	2.9%	$2,720,939	$15,819	40
15	Tisotumab Vedotin-tftv	Tivdak	Cancer	$7,123	EA	--†	--	--	--
16	Collagenase Clostridium Histolyticum	Xiaflex	Dupuytren's Contracture, Peyronie's Disease	$6,975	EA	2.4%	$250,290	$13,905	<11
17	Pegaspargase	Oncaspar	Cancer	$5,363	ML	--†	--	--	--
18	Carmustine in Polifeprosan	Gliadel Wafer	Cancer	$5,280	EA	55.8%	--	--	--
19	Selinexor	Xpovio	Cancer	$4,440	EA	69.0%	$1,126,106	$27,466	19
20	C1 Esterase Inhibitor (Human)	Berinert	Hereditary Angioedema	$4,170	EA	15.0%	$799,845	$24,238	<11
21	Ixabepilone	Ixempra	Cancer	$3,950	EA	--†	--	--	--
22	Siltuximab	Sylvant	Castleman's Disease	$3,855	EA	32.4%	--	--	--
23	Dinutuximab	Unituxin	Cancer	$3,809	ML	86.8%	--	--	--
24	Mecasermin	Increlex	Pediatric Growth Failure	$3,676	ML	-10.6%	--	--	--
25	Triptorelin Pamoate	Trelstar	Cancer	$3,046	EA	3.2%	--	--	--

* MDH analyzed retail pharmacy claims processed through the pharmacy benefit during calendar year 2024 (gathered from the Minnesota All Payer Claims Database). Many of the drugs on this list must be administered by a provider and are billed under the medical benefit, which was not analyzed for this analysis. Items lacking pharmacy claims does not necessarily mean they were not used in Minnesota.

† MDH did not receive price growth reports from the manufacturers of tisotumab vedotin-tftv (Tivdak) or ixabepilone (Ixempra), so cannot evaluate the reported net profit margin. The net profit margins of omidubicel-onlv (Omisirgee) and pegaspargase (Oncaspar) were excluded due to data quality issues.

Sources: MDH, Health Economics Program analysis of Medi-Span reference data from Wolters Kluwer's Medi-Span Suite of electronic drug data files. Additional information at Medi-Span: Drug Data Solutions for Healthcare (https://www.wolterskluwer.com/en/solutions/medi-span); MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024 to June 30, 2024.
Minnesota All Payer Claims Database - MN Dept. of Health (https://www.health.state.mn.us/data/apcd/index.html)

Figure D1. Average list price per unit in the US and foreign markets for the most expensive price growth drug families with foreign price reporting, July 2024 – June 2025



Source: MDH, Health Economics Program summary of data reported under Minnesota's Prescription Drug Price Transparency Act for the period of July 1, 2024, to June 30, 2025.

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