Capital Rx

The Clearinghouse Model:

A new pricing framework to increase efficiency and trust in the PBM industry

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Over the last decade, drug spend in the United States has grown by hundreds of billions of dollars as the net cost of prescription drugs has continually risen faster than the rate of inflation.

Nearly

1 in 4

Americans claim it's difficult to afford their medications.

Source: KFF Health Tracking Poll, 2019

The result?

Approximately one third of Americans choose not to fill their prescriptions due to the price. Nonadherence to prescribed medications has serious implications, especially for those with chronic conditions. The Centers for Disease Control and Prevention (CDC) estimates that nonadherence causes 30 to 50 percent of chronic disease treatment failures and 125,000 deaths per year, costing the United States approximately $290 billion every year in avoidable healthcare expenditures.

These egregious numbers have garnered media scrutiny, patient and provider outrage and numerous legislative efforts aimed at lowering prescription drug prices, yet year after year they continue to rise.

Even more perplexing than rising drug prices across the board are the wildly different prices that patients end up paying for the same medications, even those under the same plan filling their prescriptions at the same pharmacy.

This problem exists due to traditional pharmacy benefit managers (PBMs) using an overly complex and opaque pricing system for their own profit. PBMs administer prescription drug benefits for plan sponsors like employers, unions and government entities. Since their inception 30 years ago, the PBM market has consolidated through dozens of mergers and acquisitions resulting in large market leaders who have manipulated the drug pricing system to work in their favor.

Many times, plan sponsors are not even aware that they have a choice when it comes to selecting a PBM with a pricing and service model that best fits their needs.

This paper introduces Capital Rx, the fastest growing PBM in the United States, and their Clearinghouse Model that has unlocked the pharmacy supply chain for enduring social change.

THE PROBLEM

An inefficient market has led to an illusion of artificial drug price volatility as plan sponsors and pharmacies are charged different prices.

The broken drug pricing system stems from traditional PBMs who are now owned by large healthcare conglomerates who make it difficult for plan sponsors to offer prescription drug benefits to their employees that are not tied to their medical benefits. Having medical and pharmacy benefits managed by the same carrier may sound like an advantage, however it often leaves the plan sponsor with limited flexibility and leads to misaligned incentives. The contracting practices used by these PBMs constrain plan sponsors' visibility to claim-level data, rebates from pharmaceutical manufacturers and pharmacy reimbursements, all which have a direct effect on the bill plans pay.

In the traditional framework above, the plan sponsor, PBM and pharmacy all pay a different price, allowing for the possibility of spread pricing.

In a typical contract, price is defined as the average discount off the Average Wholesale Price (AWP) over the course of a year for drugs bucketed into categories like generic, brand or specialty.

It's important to note that there is no industry standard definition for these categories, but the current AWP structure forces drug pricing claims to be categorized within these arbitrary buckets. Traditional PBM contracts are written around validating false guarantees based on an average discount off an AWP list price measured over the course of a year. These discounts are applied to those buckets of claims, allowing traditional PBMs to fluctuate prices by moving drugs into different buckets to generate margin opportunities, known as "**spread pricing**".

The solution is simple: one price for plan sponsor, PBM and pharmacy.

AWP is an artificial number that is generally highly inflated from the manufacturer's price and can be compared to the "sticker price" of a drug. Think of it like the MSRP on an automobile: no one ever pays that list price, rather it's a starting point for negotiations. The AWP benchmark has been used for decades, but mainly because there hasn't been another reliable alternative. Through numerous investigations, the Office of the Inspector General (OIG)* found AWP to be a "fundamentally flawed" approach for pricing drugs for the purpose of reimbursement due to their inflated prices.

PBMs also use Maximum Allowable Cost (MAC) price lists to reconcile the differences between an inflated AWP and the price the pharmacy actually pays. Often times PBMs maintain multiple MAC lists, using different criteria to derive and apply prices to the lists, so no two are the same. Even under "transparent" AWP based arrangements PBMs will manipulate their multiple MAC lists to give the appearance of "pass-through" pricing to one client while greatly damaging the financial performance of another client.

PBMs artificially set drug prices – one price for the pharmacy's reimbursement and another price charged to each plan sponsor. This flawed model allows PBMs to manipulate the price of each prescription to their advantage and no one is contractually allowed to see the real prices.

The United States prescription drug market is highly inefficient and operates unlike any other market. Consider the price of gas: depending on where you are in the country, most of us can agree on the price of gas. While it may fluctuate slightly, you won't see one gas station charging $2 per gallon and another charging $7 per gallon. But when it comes to prescriptions, there's no way to verify that the price you're paying for a drug isn't twice as much as someone else. Nobody knows the actual price of prescriptions in the United States.

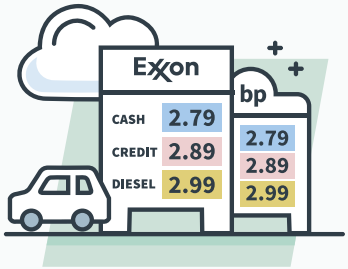
What's the price of amoxicillin?

US PHARMA MARKET

Annual Sales: $500 Billion

5-Year growth: 36%

What's the price of gas?



US GASOLINE MARKET

Annual Sales: $41 Billion

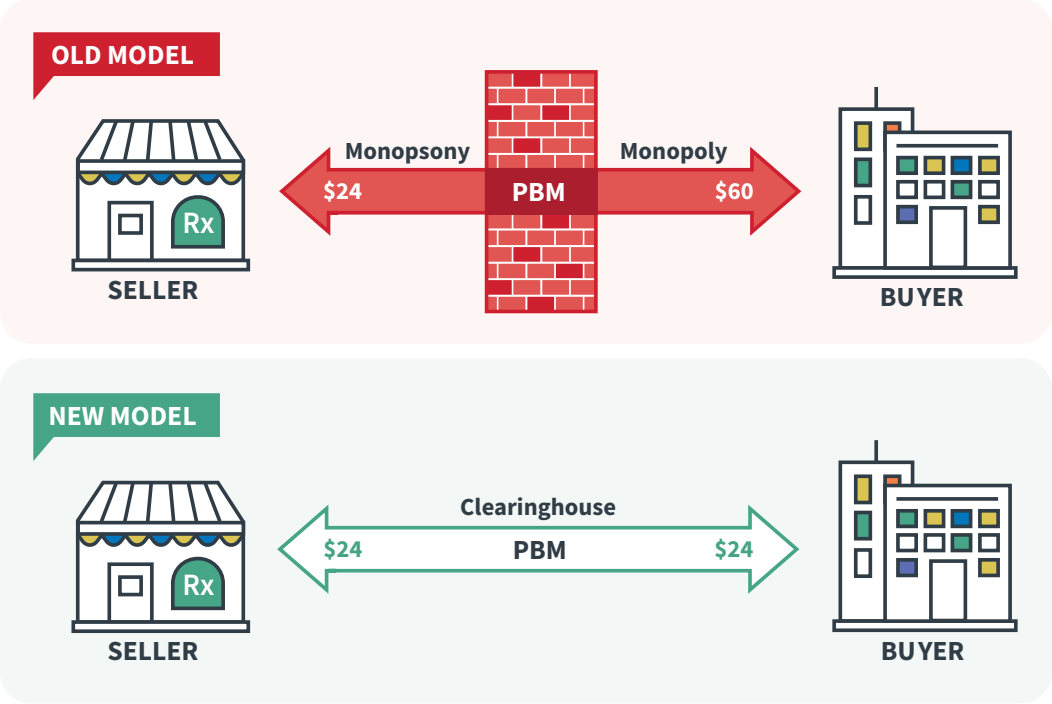
5-Year growth: 12%

The traditional way of doing business creates financial misalignment resulting in patients paying widely variable prices for their prescription drugs. This volatility of drug pricing has been a source of frustration and confusion for plan members, especially when deductibles and coinsurance come into play, and has contributed to plan sponsors and pharmacies losing dollars and trust in the healthcare system.

The Clearinghouse Model removes financial misalignment to unify the supply chain and establishes the first efficient market for drug pricing.

It's the first pricing framework that offers true claim-level accountability for prescription drug pricing. Unlike other PBM models that contractually forbid the buyer and seller to communicate directly and only allow annual reconciliation, the Clearinghouse Model encourages the pharmacy to verify charges to the plan sponsor, and plan sponsor to see the reimbursement to the pharmacy.

The Clearinghouse Model simplifies the typical PBM contract. Rather than bucketing drugs into arbitrary categories and pricing based on the average over an entire year, each drug has specific NDC-11 unit level pricing and each claim transaction reflects that actual price.



What is NADAC?

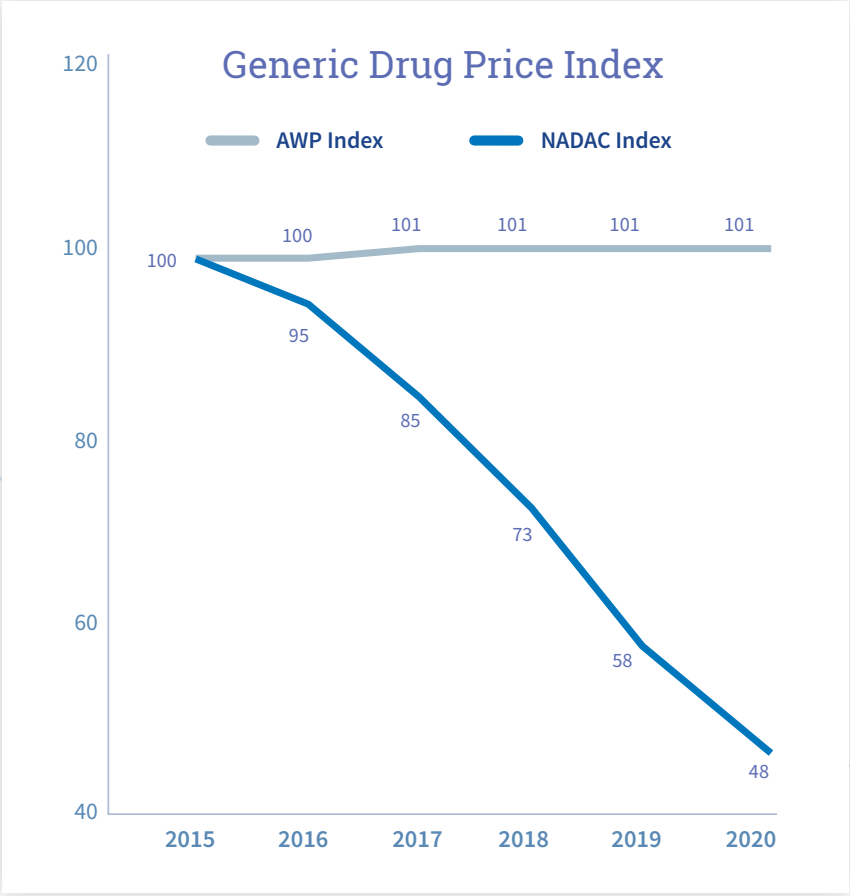
To address inconsistent pricing as a result of AWP, the Clearinghouse Model uses the National Average Drug Acquisition Cost (NADAC) database as the source for drug prices. NADAC data is maintained by the Centers for Medicare and Medicaid and is reflective of acquisition costs of over 600 retail pharmacies in the U.S. to ensure price standardization.

NADAC is reported on an NDC-11 basis for 98.5% of dispensed drugs and only updates when the price changes more than 2%. It's published weekly online and is available for free, making it extremely simple to audit any drug claim.

This pricing approach aligns drug prices with average actual pharmacy drug costs rather than manufacturer list prices, so it is not subject to the inflationary tendencies of AWP.

What's the difference between AWP and NADAC?

👍	NADAC takes a simple average of the drug acquisition costs submitted by retail community pharmacies
👍	NADAC uses one pricing logic across all claims - no claim can be moved or excluded
👍	NADAC prices decrease over time, specifically generics with a greater than 50% reduction over five years



What's the difference between AWP and NADAC?

	AWP is an artificial number completely unrelated to acquisition cost
	Using AWP as a source price supports contractual games that PBMs play
	AWP continues to rise year after year

This graph shows year over year price trends for the top 1,200 generics in Capital Rx's 2019 book of business, weighted by NDC utilization, for which there are both AWP and NADAC unit prices.

Since 2015, AWP prices are relatively flat (increase 1%) while NADAC prices decrease by more than 50%.

THE SOLUTION

Capital Rx, a fast-growing PBM with a profound vision for the future of how pharmacy benefits are priced and administered in the US, believes that price visibility is the first step to understanding value and rebuilding trust within the healthcare industry.

Under their Clearinghouse Model, Capital Rx is the first national PBM to offer a NADAC-based commercial retail network. This approach creates stable claim-level prices for retail pharmacies, eliminates artificial MAC price volatility for patients and guarantees a full pass-through of any manufacturer-derived revenue to plan sponsors. It addresses pain points for all critical participants in the pharmacy transaction.

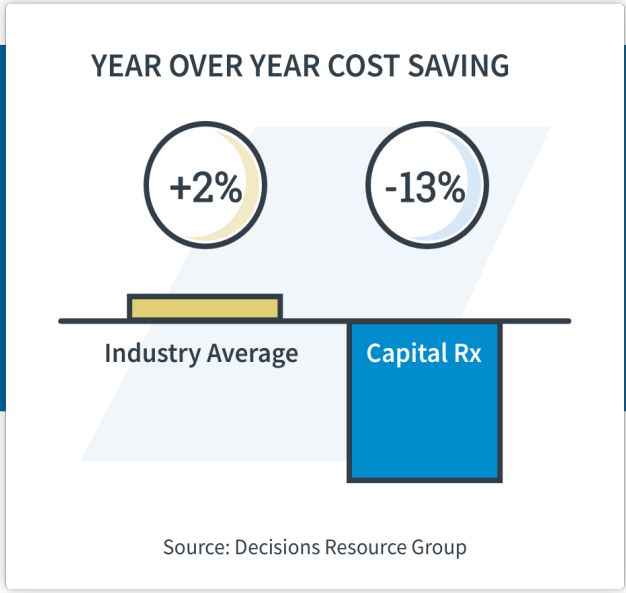
What makes the Clearinghouse Model unique?

1. All pricing terms are enforced at the claim level – this means no annual average effective rates
2. All drugs have a specific NADAC price which behaves consistently across brands and generics – eliminating arbitrary categorization and generic lists that can be manipulated easily by a PBM to inflate performance and generate hidden margins
3. Avoids AWP unless absolutely necessary: approximately 99% of claims have a NADAC price, which follows the actual economics of the pharmacy supply chain

How does it compare to other models?

	Clearinghouse		Pass-Through		Traditional	
Ability of PBM to Profit from Retail Markup	✓	PBM margin isolated to a flat administrative fee.	?	Network access fees & claw-backs may exist.	✗	Markup of ingredient cost at claim level.
Accessibility of Pricing Source	✓	NADAC available for free at Medicaid.gov.	✗	AWP managed by for-profit company, behind paywall.		
Gameplay with Brand/ Generic Definitions	✓	Claim-level pricing renders B/G definitions obsolete.	✗	PBM easily re-buckets drugs with caveats & exclusions.		
Claim-Level vs. Annual Guarantees	✓	NADAC guaranteed claim-by-claim, auditable in real-time.	✗	Annual averages, calculated long after year end.		
Pricing Stability	✓	Single NADAC price list applied for all clients.	✗	PBM controls/manipulates claim-level price (i.e. MAC).		
Simplicity of Audit	✓	Single price list, with no definitions or exclusions.	✗	Contract nuances consume tremendous audit resources.		
Ability to Verify Reimbursements	✓	835 Transaction File provided upon request.	✗	All transactions self-reported by PBM.		

The Clearinghouse Model has produced Year over Year **cost reduction of -13%** for Capital Rx clients, **over 6x higher than the industry average of 2%**. By establishing a competitive marketplace for drug pricing, Capital Rx focuses its resources on unlocking real value through a high-touch service model that is unprecedented in the healthcare industry.



Source: Decisions Resource Group

The Clearinghouse Model simplifies contracting, auditing and reduces costs for both plan sponsors and pharmacies.

By tearing down the wall that has prohibited communication between pharmacies and plan sponsors, the Clearinghouse Model separates PBM profit from drug pricing, eliminates artificial guarantees inherent in using AWP as a source price and removes any possibility of contractual games.

Capital Rx's Clearinghouse Model goes beyond the promises of transparency and alignment claimed by other PBMs and aims to completely disrupt the industry. It proves that plan sponsors can implement a pharmacy program that produces massive savings without sacrificing the highest quality member care.

How does Capital Rx make money?

- Capital Rx's sole source of revenue is a flat administrative fee. No owned dispensing assets. No markup of drugs. No retention of pharma revenue.

What does the acronym NADAC represent?

- National Average Drug Acquisition Cost

Where did NADAC come from and why is it used?

- NADAC was developed by CMS after investigations by the Office of Inspector General revealed "fundamental flaws" with AWP. NADAC is designed to provide payers with the most accurate representation of real-world retail drug prices in a timely, comprehensive and publicly available format.

What payers typically use NADAC pricing as the cost basis for their drug contracting?

- NADAC is used to determine retail pharmacy reimbursement for over 30 State Medicaid payers. Despite its wide use among Medicaid plans, traditional PBMs have attempted to prevent this index from being introduced to the Commercial market because it eliminates their ability to profit from the spread between their costs and the fees they charge their clients.

How is NADAC data gathered and determined?

- NADAC is determined by a survey of more than 600 retail pharmacies. The monthly survey and its resulting data reflect actual acquisition cost pricing for more than 98% of all dispensed drugs.

Where can the NADAC drug pricing file be located? How often is it updated?

- The NADAC drug pricing file is updated monthly and can be downloaded directly by clicking the following link: https://data.medicaid.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d

How does NADAC apply to the pricing logic of specialty and mail service drugs?

- As part of the overall Clearinghouse Model, there are established and disclosed NDC-11 prices for all drugs dispensed at mail and specialty pharmacies. However, NADAC prices are based on retail pharmacy surveys because they best capture retail acquisition costs. For this reason, Capital Rx has negotiated unit-prices for each NDC-11 with our Clearinghouse mail and specialty partners. In almost all cases, unit-prices for commonly utilized mail and specialty drugs are lower than NADAC rates. However, to ensure optimal mail pricing competitiveness, Capital Rx's Clearinghouse Model includes the lower of (a) established unit cost with mail partner; (b) NADAC; and (c) U&C.

How are specialty claims adjudicated and priced in the event they are dispensed at retail?

- Available NADAC prices utilized, or a flat rate of AWP-19% shall apply, for any specialty drugs dispensed at retail for which a NADAC price is not established.

What discount is applied to the approximate 1% of drugs dispensed at retail that do not have an associated NADAC price?

- Capital Rx applies a flat discount of AWP-19% to this small basket of drugs which primarily includes vaccines and some diabetic testing strips.

When comparing drug pricing models, what benefits do NADAC present over AWP, WAC, or DP?

- Through numerous investigations, the Office of Inspector General found that AWP-based reimbursements were "fundamentally flawed," causing Medicaid to overpay for certain drugs. As a result, multiple pricing data sources became available, including Wholesale Acquisition Cost (WAC), Average Sales Price (ASP) and Direct Price (DP). While these fundamentally-flawed models are available for consideration, NADAC is the only pricing source that does not include manufacturer rebates and comes directly from the retail pharmacies purchasing the drugs.

**Replacing AWP: Medicaid Drug Payment Policy, Office of Inspector General, July 2011*