

'21

Annual Report

# Making health policy work for patients

How platform solutions  
enable more affordable drugs



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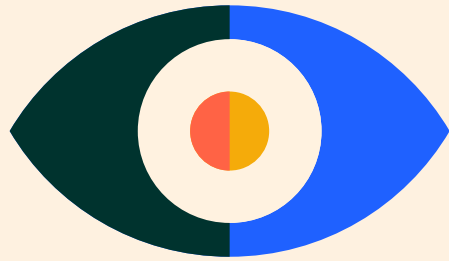
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## Perspective

A letter from Kalderos  
CEO Jeremy Docken

Everyone wants patients to have access to the drugs they need at a price they can afford. Yet many efforts to make drugs more affordable have continued to fall short, because they've failed to center the needs of the patient, the most important stakeholder in the healthcare system.

Before founding Kalderos, I spent a decade in consulting, working with the pharmaceutical industry to address the systemic issues at the intersection between drug discount programs and the complex ecosystem of drug manufacturers, payers, providers and pharmacies (a.k.a. the "drug channel"). That experience impressed upon me the magnitude and complexity of the failings in the current system.

Just as importantly, I've seen those failings firsthand. As my mom's former financial and healthcare power of attorney, I did my best to help her choose the most cost-effective options under Medicare Part D. Yet her out-of-pocket costs for 15+ different medications remained incredibly high, putting financial stress on the whole family. Even as an "expert" myself, I found navigating the complexities of this system totally overwhelming. Yet elderly patients without that industry knowledge are left to navigate it every day.

Patients are in urgent need of an innovative solution. I became determined to help find it, and in 2016, together with my co-founders,

I launched Kalderos. Our mission: developing the world's first Drug Discount Management platform, a unifying technology that would bring transparency, trust and efficiency to drug discount and rebate programs.

Our first area of focus was the 340B Drug Pricing Program, which provides essential support for healthcare providers that serve vulnerable populations, creating savings that allow for better care for millions of patients in both urban and rural communities. For 30 years, stakeholders have been trying to find a reliable way to ensure accurate payments and reduce friction between payers, providers and drug manufacturers who interact with the 340B program, in order to keep the program running as intended.

Kalderos came at it with a novel approach: connect the stakeholders; enable simple, streamlined communication; and apply machine learning to create smart data science tools.

By fall of 2017, there were five of us at Kalderos. By 2018, our team had grown to 11, and we'd already identified over \$100 million in misapplied discounts across a number of drug discount and rebate programs. In 2019, we raised \$7 million in Series A funding. We quadrupled our team. We moved to a bigger office – twice. We began building not just a product, but a company that could successfully scale to meet the

challenges we'd set out to solve. Our new and growing team came together to deliver a first-of-its-kind platform solution to benefit all 340B program stakeholders.

In 2020, we launched that solution: 340B Pay. We made the shift to remote work during the pandemic while continuing to onboard dozens of new team members. And we raised \$28 million in Series B funding, making us more ready than ever to fulfill our mission of solving systemic problems in the healthcare system and empowering all of healthcare to focus on the health of people.

As we dive deeper into 2021, we see big developments on the horizon for the business of healthcare. Industry trends are driving change; so is the massive impact of COVID-19. A new administration has begun to tackle the ongoing challenge of drug affordability, and policy shifts will likely follow.

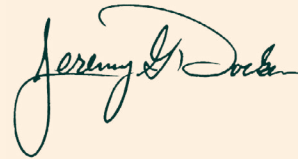
While our government leaders align on policy, Kalderos is building the data-driven platform to help our partners turn those policies into action, complying smoothly and efficiently. We measure our success by how we empower others to focus on improving the lives of patients.

**During this pivotal moment, it's the perfect time to launch our inaugural annual report.**

In this yearly update, we'll share our perspective on the state of the industry, inform our stakeholders on the progress we've made in executing against our goals, and expand on our vision for the future.

Kalderos is built on a few core values: We are inspired. We are steadfast. We are collaborative. We are courageous. And we always strive toward excellence. The more we grow, the better ability we have to enact these values. I'm so excited for what we'll build together in 2021.

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# 02

## Problem

The big picture problem  
of out-of-pocket costs

## Prescription drugs aren't affordable for every patient, and it's harming their health

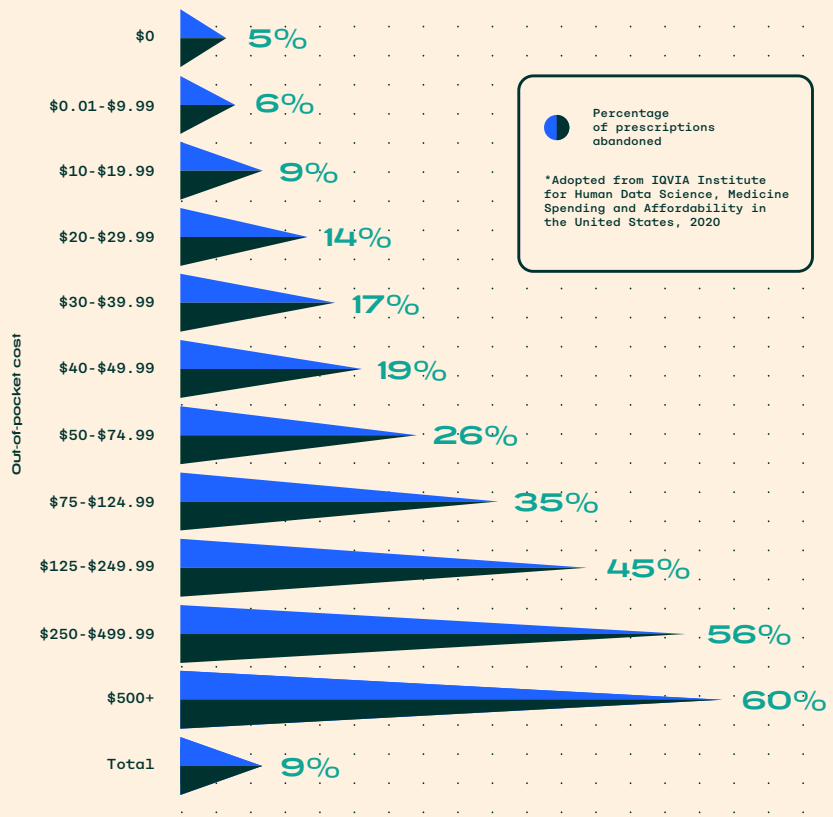
1 in 4 Americans struggle to afford their prescription drugs.<sup>1</sup> Maybe you're one of those 1 in 4, and if not, you almost certainly know someone who is – a family member, a neighbor, a coworker or a friend. Maybe that person looks like Annie, a Type 1 diabetic who can't survive without insulin; sometimes she has to choose between paying the heating bill or affording her monthly prescription.

Or maybe they look more like Eugene, an elderly heart patient who is enrolled in Medicare Part D; the rising out-of-pocket costs of his heart medications mean he's begun rationing pills, taking just half the recommended dose. Or they could even be like Jess, who has employer-sponsored insurance with a high deductible. Her coworkers don't know she suffers from chronic pain, or that she frequently finds herself unable to afford her medications when her annual deductible resets; they only know that on bad pain days, she comes to work seeming tired and "off."

Around 1 in 2 Americans take at least one prescription drug; elderly people or those with chronic conditions often take several.<sup>2</sup> In 2019, total spending on prescription drugs in the United States was about \$370 billion, increasing 5.7% from the previous year.<sup>3</sup> About 14% of that cost came directly from patients' pockets<sup>4</sup>, causing hardship.

### The high out-of-pocket cost of prescription drugs is also impacting America's health.

One survey showed that 1 in 5 adults in the U.S. has failed to complete a prescribed course of medicine because it cost too much; only 1 in 10 patients said the same in Germany, Canada or Australia.<sup>5</sup> In 2019, 9% of all U.S. prescriptions were abandoned<sup>6</sup>, likely in large part due to cost; only 5% of prescriptions with no out-of-pocket cost are abandoned, but 45% of those that cost more than \$125 out-of-pocket are abandoned and 60% of those that cost more than \$500 are abandoned.<sup>7</sup>



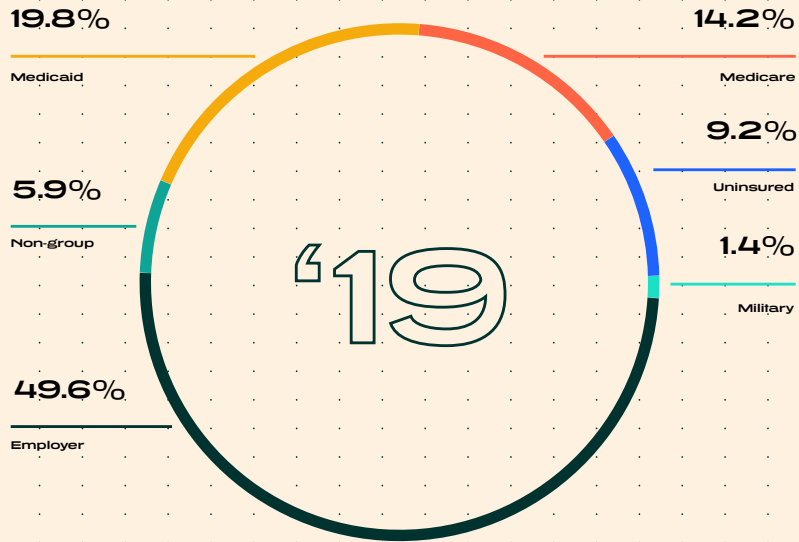
Because of how Medicare plans are designed, high out-of-pocket costs particularly impact Medicare enrollees, who represent around 1 in 6 Americans. These high out-of-pocket costs for Medicare Part D enrollees are a serious burden, because even a small rise in costs can have big impacts. A recent study found that when Medicare beneficiaries' out-of-pocket costs rise by just \$10 per prescription, it led to a 23% drop in overall drug consumption, and a tragic 33% increase in mortality.<sup>8</sup>

### The relationship between out-of-pocket costs and prescription abandonment

The more a prescription drug costs a patient at the pharmacy counter, the less likely the patient is to take it. So high out-of-pocket costs have a real impact on patients' health. This 2019 data from IQVIA defined a prescription as "abandoned" when it was not dispensed to a patient within 14 days of the initial fill.

Source: IQVIA LAAD Sample Claims Data, Dec. 2019



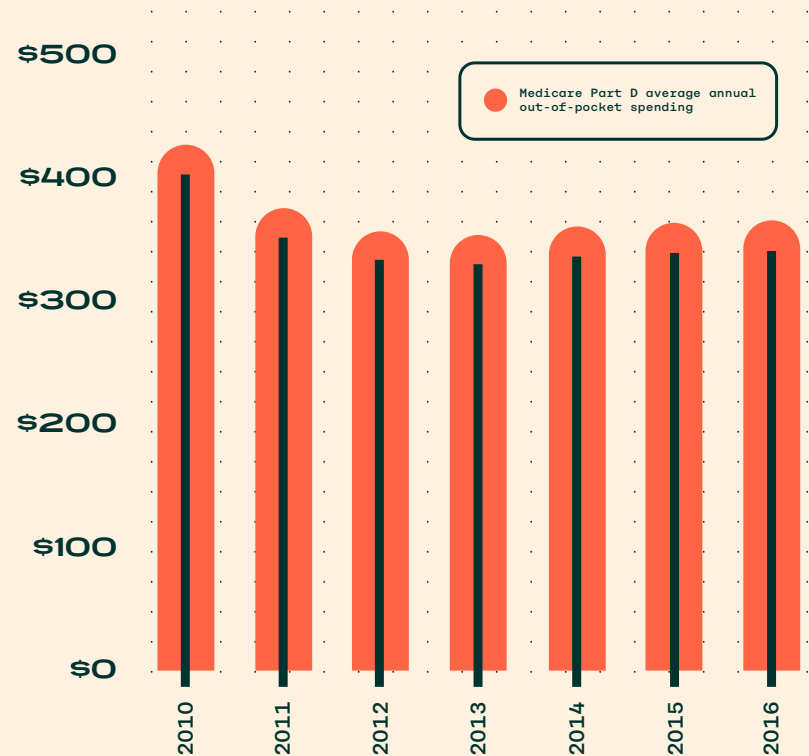


\* To sum to 100, percentages account for responders with more than one type of coverage

### Annual out-of-pocket costs for Medicare Part D beneficiaries

Medicare Part D enrollees have significantly higher annual out-of-pocket costs than other patients. Studies show that higher out-of-pocket costs make it less likely that a patient will take all their medicines as prescribed; for instance, the study noted above, which found that an increase of just \$10 per prescription for Medicare beneficiaries led to a 23% drop in overall drug consumption.<sup>9</sup> When patients fail to adhere to the treatments advised by their healthcare team, they have worse health outcomes and are more likely to become hospitalized or die.

**Source:** KFF Report, How Does Prescription Drug Spending and Use Compare Across Large Employer Plans, Medicare Part D, and Medicaid, 2019; CMS National Health Expenditure Data, 2019; US Census, National Population Totals and Components of Change: 2010-2019



### Percentage of U.S. population across different insurance types and growth of Medicare Part D

Around 1 out of 6 Americans are currently enrolled in Medicare. That number has risen over the past two decades as life expectancies increase and the Baby Boomer generation ages into Medicare. For instance, the number of Americans enrolled in Medicare Part D grew from 22 million in 2006 (when the program was created) to around 47 million today. These trends are expected to continue.

**Source:** KFF State Health Facts data, Health Insurance Coverage of the Total Population; KFF, An Overview of the Medicare Part D Prescription Drug Benefit, 2020.

## Drug discount and rebate programs have historically been used for purposes other than reducing patient out-of-pocket costs

Policymakers have long been concerned about the price of drugs, but they've faced challenges into getting to the root of the issue. While drug rebates and drug discounts have regularly been used in the U.S. healthcare system, they've been applied to a variety of purposes other than ensuring that the drug is affordable for patients at the pharmacy counter.

**One of those purposes has been to reduce insurance premiums.**

In Medicare Part D, different health plans compete for enrollees on the basis of premiums, benefit structures, specific drugs covered and pharmacy networks.<sup>10</sup> Plans negotiate rebates from drug manufacturers who compete with other manufacturers for preferred formulary placement (the formulary is the list of drugs the plan will cover). The more restrictive a plan's formulary is, the greater negotiating leverage the plan has in order to obtain larger rebates from manufacturers. The rebates collected by the plan are used to keep premiums lower

for all enrollees, helping the plan compete for enrollees against other plans.

Unfortunately, because the rebates are used to keep premiums low instead of reducing the out-of-pocket costs for drugs, the result is a system where the sickest patients who need multiple drugs each month find themselves struggling to afford their medications, while their utilization generates rebates that allow healthier patients who take fewer drugs to benefit from lower premiums. In short, the rebates generated by sicker patients subsidize low premiums for healthy patients, not exactly how most people imagine health insurance should work.

In the last days of the Trump administration, the Department of Health and Human Services issued a final rule that would require plans to forgo traditional rebates and instead use their negotiating power to negotiate lower drug prices on behalf of patients, with the discount applied

at the pharmacy counter.<sup>11</sup> While this rule would help reduce out-of-pocket costs for patients who need multiple drugs, the loss of rebate dollars would cause the plans to increase premiums or require that federal taxpayers contribute billions more towards reducing premiums.

**Drug discount programs have also been used as a revenue source.**

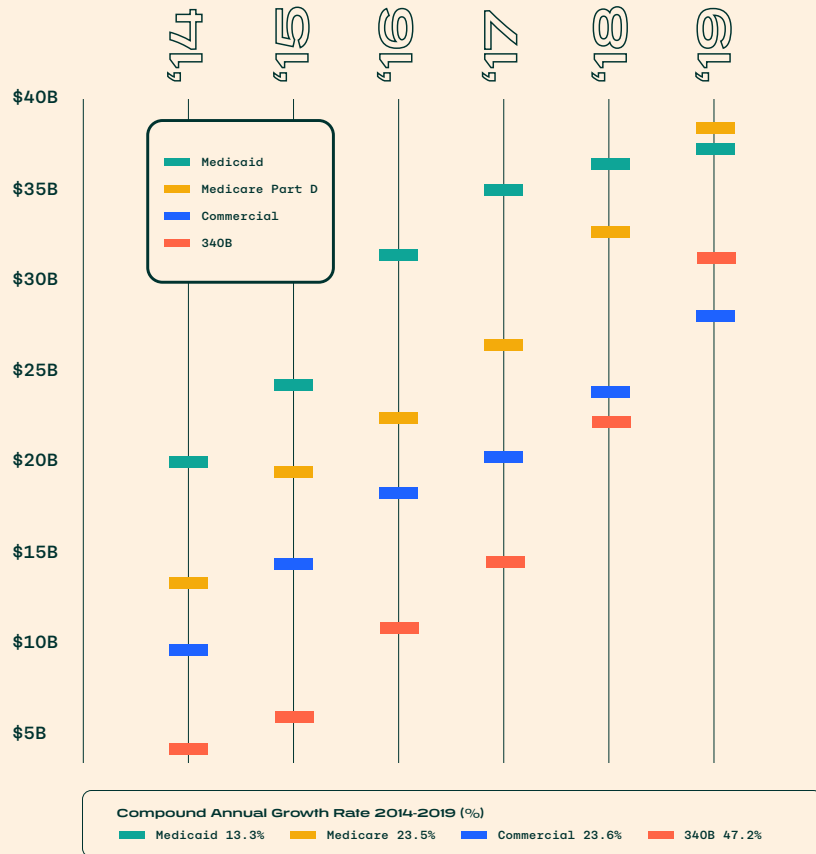
The 340B Drug Pricing Program is a federal program that allows certain safety-net healthcare providers, called “covered entities,” to purchase drugs from drug manufacturers at significant discounts. The covered entities then sell the drug to the patient at cost, or provide the drug to the patient for free if the patient cannot afford it.

However, if the patient has insurance, the healthcare provider’s ability to purchase drugs at a low price and then be reimbursed at a much higher price by the patient’s insurance offers the healthcare provider a much-needed revenue stream. Covered entities then use this additional revenue stream to help fund their safety-net mission.

While it is entirely possible that covered entities could always pass the discount on to patients, many covered entities, specifically Federally Qualified Health Centers (“FQHC”), would see millions of

dollars of critical revenue disappear. This would cause nearly every FQHC to reduce services to some of the neediest patients in our communities, or even cause the FQHC to shut down entirely, unless state and federal governments decide to make up the loss in revenue with additional grant dollars – something most lawmakers are reluctant to do.

While there is nothing wrong with using drug discounts and rebate programs for purposes other than reducing patient out-of-pocket costs, these additional uses of discounts and rebates makes it challenging for policymakers to implement changes to improve drug affordability.



### Annual average out-of-pocket spending per capita in the U.S., for large employer-sponsored healthcare plans, and for Medicare Part D

Though rebates and discounts have risen steeply, out-of-pocket costs haven't declined in response. For most patients, out-of-pocket costs are about the same. Even Medicare Part D, while seeing a slight decline, remains high. The remarkable growth in rebate and discount programs isn't helping patients at the pharmacy counter.

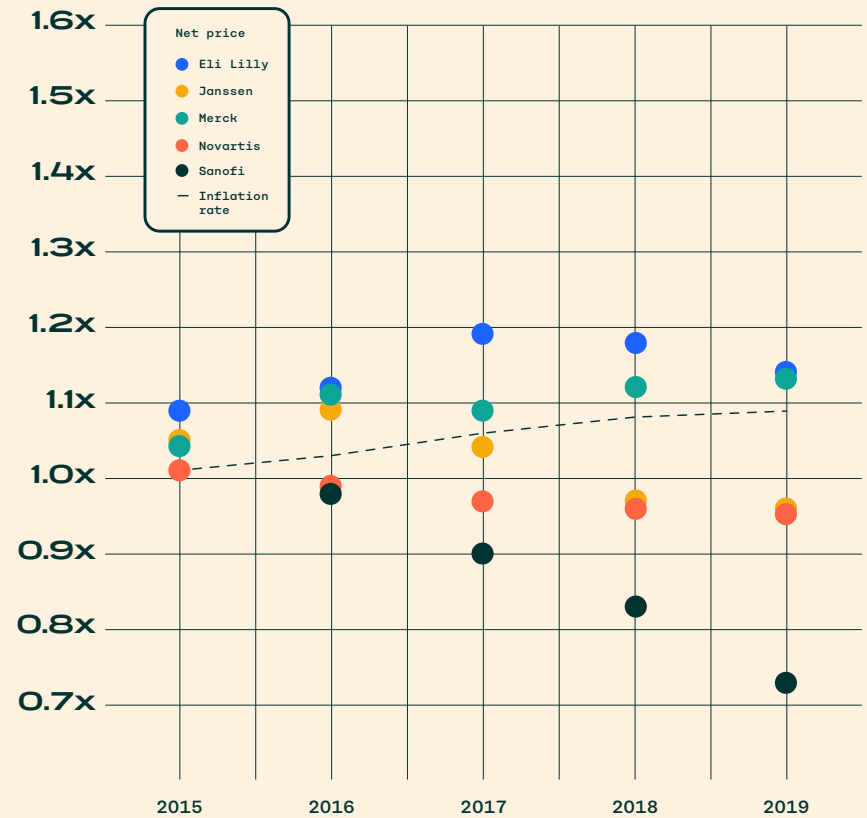
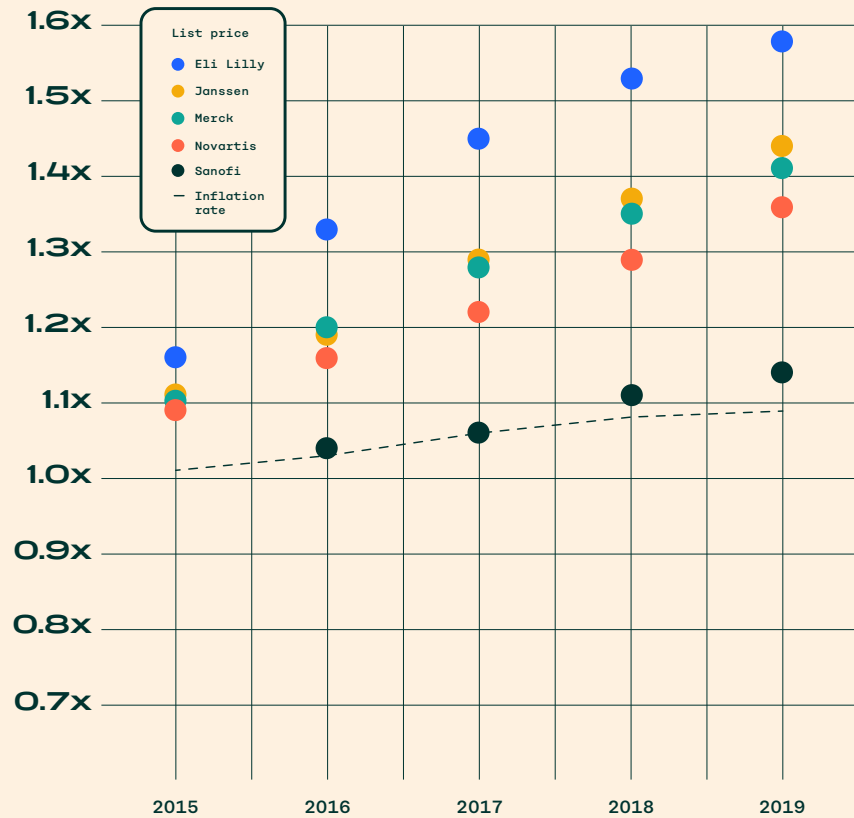
**Source:** KFF Report, How Does Prescription Drug Spending and Use Compare Across Large Employer Plans, Medicare Part D, and Medicaid, 2019; CMS National Health Expenditure Data, 2019; US Census, National Population Totals and Components of Change: 2010-2019



### The growth of rebates and discounts across programs

Rebates and discounts have risen steeply since 2014. The 340B Drug Pricing Program has seen particularly dramatic growth.

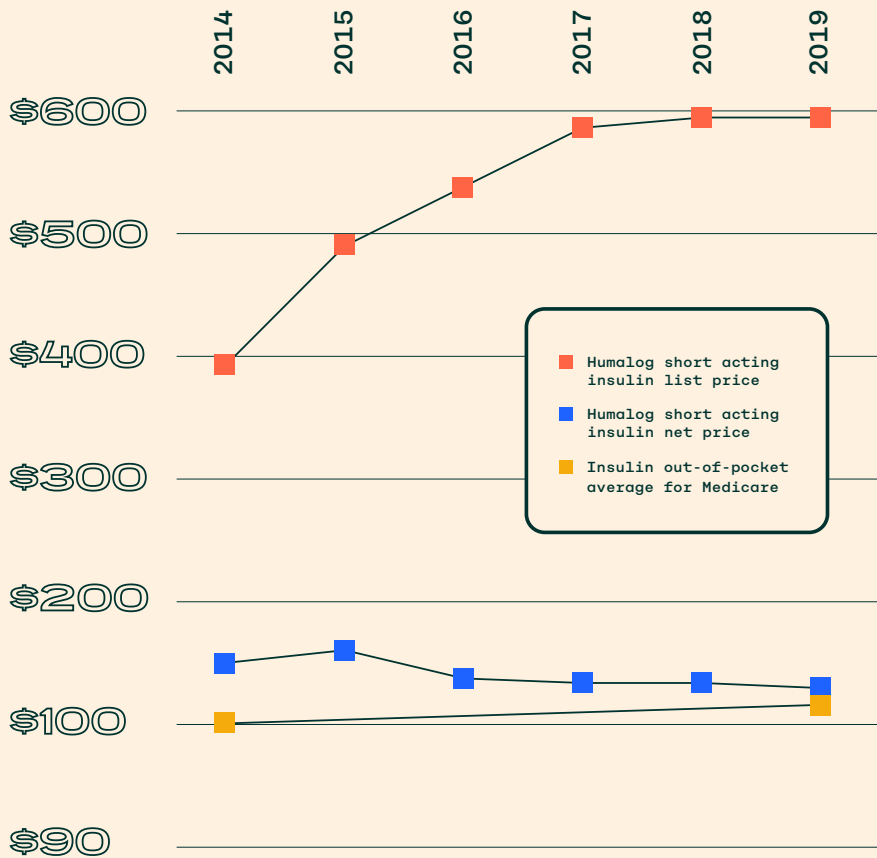
**Source:** MACPAC, Medicaid Drug Spending Trends, 2019; CMS, Medicare Trustees Report, 2020; CMS, Medical Loss Ratio summary data, 2020; Drug Channels, New HRSA Data: 340B Program Reached \$29.9 Billion in 2019, 2020



### List price and net price aren't following the same trajectory

List price is the published price set by the manufacturer. List prices have risen steeply since 2015, and that gets a lot of attention in the news. Conversely, net prices are the price the manufacturer actually receives after discounts, rebates and other price concessions. For the past five years, net prices have mostly remained flat, and in some cases even failed to keep pace with inflation. This widening discrepancy is driven by the steeply growing cost of discounts and rebates, which reached an unprecedented \$187 billion in 2020.<sup>12</sup>

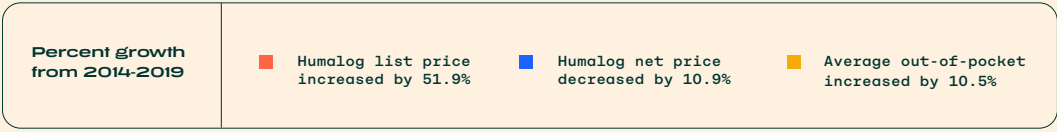
**Source:** Drug Channels report, Five Top Drugmakers Reveal List vs. Net Price Gaps, 2020; U.S. Bureau of Labor Statistics, CPI for All Urban Consumers (CPI-U).



**Insulin provides one clear example of a growing gap between list and net prices**

The high out-of-pocket cost of insulin is hugely concerning for many. A recent report published by the bipartisan leaders of the Senate Finance Committee outlined how list prices have risen for insulin, along with commercial rebates. The report describes how the three major pharmaceutical companies that manufacture insulin in the U.S. “blamed [pharmacy benefit managers] PBMs for their demand for ever-higher rebates which has caused them to raise list prices to maintain profitability and patient access.”<sup>13</sup> This chart shows how list prices have risen for Humalog, a type of insulin, while net prices declined and out-of-pocket costs also rose. (In this chart, average out-of-pocket cost for insulin is computed based on nine different insulins, including the top five products in terms of Part D spending.)

**Source:** American Diabetes Association, Impact of Higher Insulin Prices on Out-of-Pocket Costs in Medicare Part D, 2020; Eli Lilly and Company: Integrated Summary Report, 2018, 2019



## Misapplied discounts drive up the cost of drugs

Drugmakers participate in a complex, overlapping network of drug rebates and drug discount programs, both those mandated by laws and those created via private contracts.

This system includes discounts paid to providers, like the federally administered 340B Drug Pricing Program, as well as discounts privately negotiated by group purchasing organizations (GPOs). It includes discounts given to state payers, as in the Medicaid Drug Rebate Program. It includes rebates and other fees paid to pharmacy benefit managers (PBMs) and other payers. It also covers direct patient discounts through co-pay coupon programs. **Altogether, these rebates and discounts added up to \$187 billion in 2020.**<sup>14</sup>

Our research shows that misapplied discounts and rebates are rampant. And as the system becomes more complicated, they're a growing problem.

These misapplied discounts – what the industry calls “noncompliant discounts” – are causing conflicts between payers, providers and drug manufacturers. With the world focused on overcoming the COVID-19 crisis, these conflicts are causing a lack of trust at a time when we most need our healthcare system to focus on improving the health of patients.



## The 340B Drug Pricing Program, the Medicaid Drug Rebate Program and duplicate discounts

Since 2016, Kalderos' initial focus has been on the 340B Drug Pricing Program, which represented about \$44 billion in discounts in 2020, and its overlap with Medicaid, which represents another approximately \$37 billion in annual rebates.<sup>15</sup>

Enacted by Congress in 1992 (and substantially expanded in 2010), the 340B program was created to help healthcare safety-net organizations make the most of their resources and fulfill their mission of providing healthcare services to vulnerable communities. Through this program, drug manufacturers agree to make prescription drugs available at deeply discounted prices to qualified providers ("covered entities") to dispense to their own patients.

Congress also specified in the original 340B legislation that manufacturers should not be subject to "duplicate discounts" at

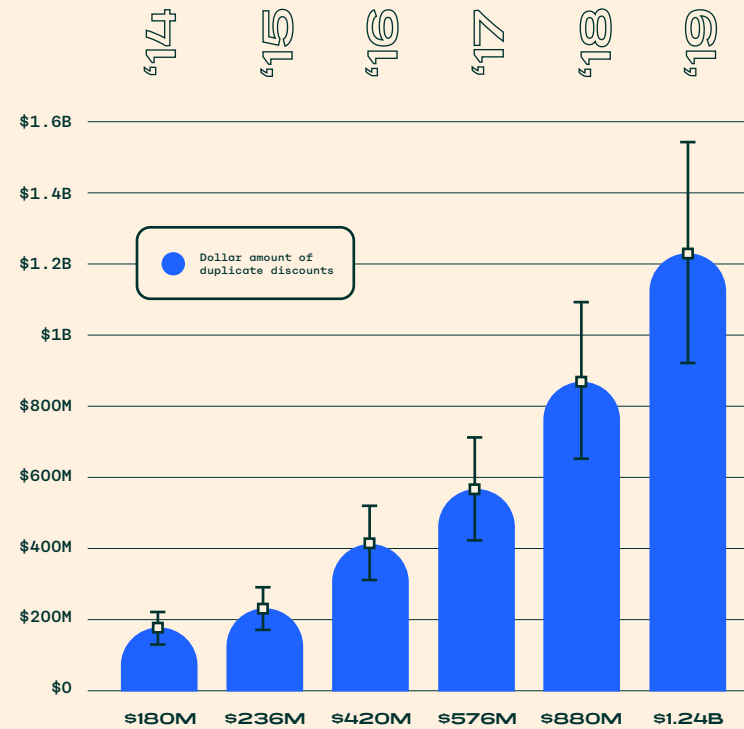
the intersection of Medicaid and 340B, which often serve the same patients. If a drug is purchased at 340B prices, the law says that manufacturers don't have to pay state Medicaid agencies a rebate on that same dispense.

The prohibition on duplicate discounts is designed to protect manufacturers from paying more than the total cost of the drug, a net loss which drives up costs for other patients. But preventing duplicate discounts from happening is largely left up to the covered entities and the states. Unfortunately, despite the best efforts of all parties, dysfunction in the system has made identifying and resolving duplicate discounts an ongoing challenge.

Government agencies responsible for overseeing these discount programs have published similar findings in reports going back years. As recently as January 2020, the non-partisan government watchdog, the Government Accountability Office,



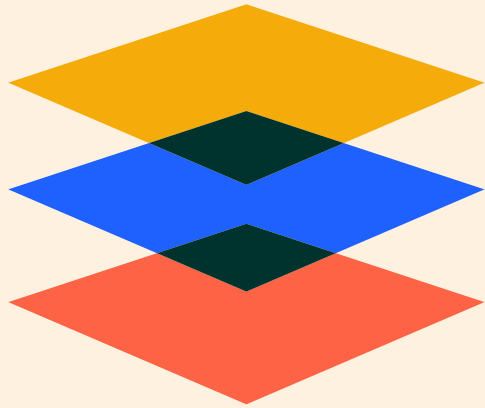
released a report titled “340B Drug Discount Program: Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement.” According to the GAO report, “limitations in the Department of Health and Human Services’ (HHS) oversight... may increase the risk that duplicate discounts occur. ...Given these limitations in federal oversight, HHS does not have reasonable assurance that states and covered entities are complying with the prohibition on duplicate discounts.”<sup>16</sup>



### As the 340B program grows, the cost of misapplied discounts grows, too

Kalderos’ findings suggest that 3-5% of 340B discounts and Medicaid rebates are duplicates. As the 340B program has grown, the financial impact of duplicate discounts has grown, too. As of 2019, that 3-5% adds up to at least \$933 million in duplicate discounts, potentially as high as \$1.6 billion. Kalderos estimates that around 68% of that stems from Medicaid managed care organizations (MCOs), which contract with state Medicaid agencies to manage healthcare services for beneficiaries on the state’s behalf. This is now the most common way that states deliver Medicaid services, but federal regulatory oversight of 340B is focused exclusively on Medicaid fee-for-service (FFS), in which Medicaid reimburses healthcare providers directly.

**Source:** Drug Channels, New HRSA Data: 340B Program Reached \$29.9 Billion in 2019, 2020; Kalderos Internal Data



# 03

## Analysis

The drug channel challenges  
that make drug discount  
programs so tough to manage

## Dated infrastructure undermines 21st century drug channels

The drug channel is big, complex and slow to change. Most of the system's existing challenges could be solved with efficient technology. Instead, legacy systems pose ongoing obstacles, which are time-consuming and costly to resolve.

One major source of friction: the fragmented systems burdened with managing data about drug discounts, provided when the pharmacy or provider purchases the drug, and drug rebates, which are determined after the drug is dispensed to a patient. Medicaid, private insurers, healthcare providers and drug manufacturers all have their own formats, systems and invoices. Where drug discount and rebate programs overlap, key identifiers for specific drugs, pharmacies, providers and dispenses are often inconsistent or missing.

When disputes arise, they're typically addressed on a case-by-case basis over phone or email, which is a lengthy, often unproductive process. Resolution is difficult.

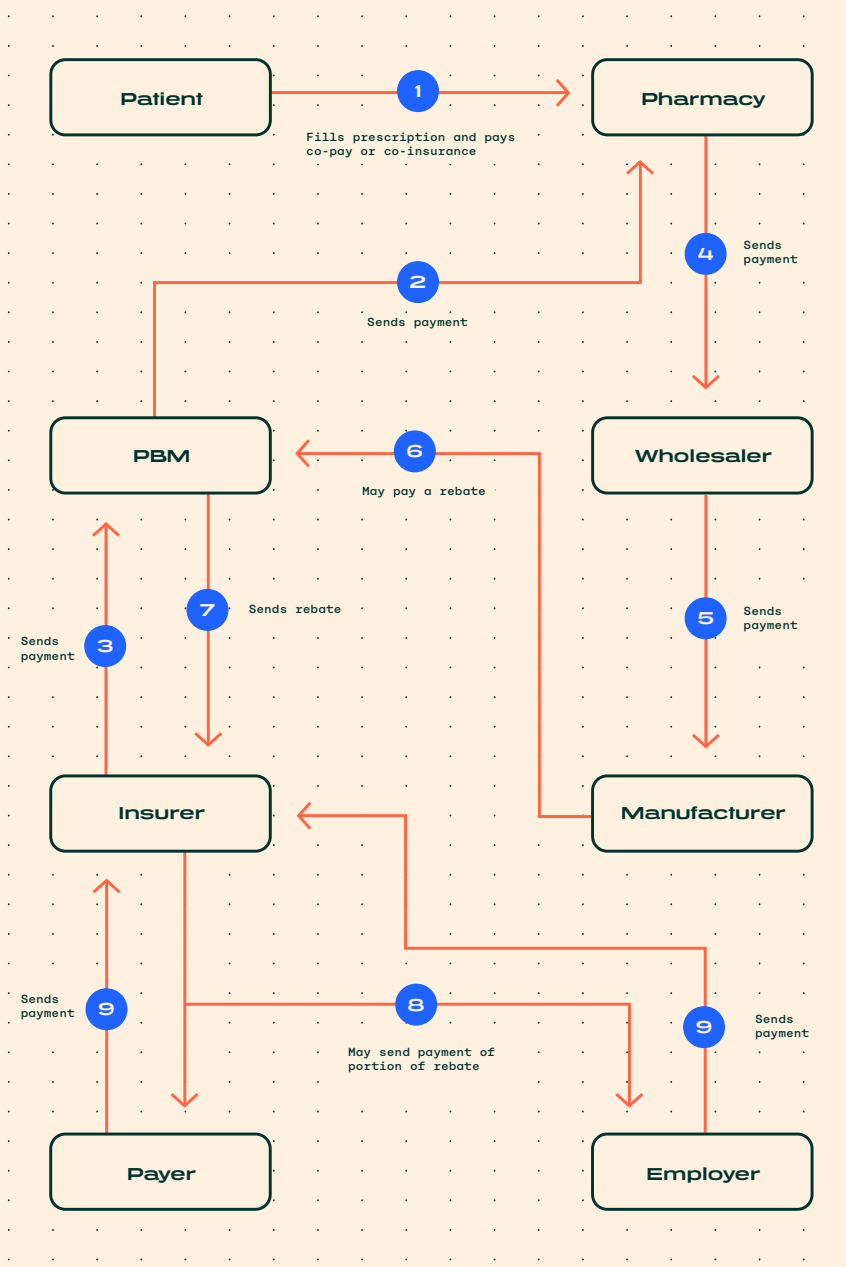
Platform technologies can make instant payments and fast communication between manufacturers, pharmacies and providers effortless, yet

industry stakeholders are still relying on legacy systems that turn accurate invoicing into a multiyear project.

## An inefficient drug channel allows fraud, waste and abuse

Noncompliance in drug discount and rebate programs is tough to solve partly because it's tough to identify. The flow of funds and data in the drug channel is often inefficient and convoluted, obscuring the source of waste.

When an insured patient fills a prescription, they typically pay a co-pay or co-insurance (along with a health insurance premium for coverage that includes prescription drug benefits). The co-pay goes to the pharmacy, and the PBM also pays the pharmacy. The insurer pays the PBM. The pharmacy pays a drug wholesaler. The wholesaler pays the manufacturer. The manufacturer may pay the PBM a rebate, and the PBM may also pay some of that rebate back to the payer or employer.



All for just one prescription.

Factor in the complex matrix of drug discount and rebate programs, including 340B, Medicaid, Medicare Part D rebates, co-pay coupon cards, patient assistance programs and more, and things get even more complicated.

The patient only knows what they pay at the pharmacy counter, and has little way of untangling the complex web of contracts and pricing structures underlying it. Even players in the drug channel have little insight into the network as a whole. So, when fraud, waste and abuse occur, it's difficult to identify. And the patient, who is most harmed by this dysfunction due to its impact on their prescription drug costs, has the least visibility into what's causing it.

To uncover the waste in the system, first it has to be visible.



## How systemic inefficiencies in the drug channel also lead to challenges in 340B

The 340B Drug Pricing Program is weakened by many of the issues that plague the pharmaceutical supply chain as a whole. These problems are precisely why the program does not always run as intended.

Dated technology, inadequate infrastructure and incompatible systems hamper clear communication between covered entities and state Medicaid offices, leading both parties to request a discount on the same dispense. Without transparent data, manufacturers can't identify these duplicates either.

The convoluted flow of funds also impedes transparency. Covered entities make their deeply discounted drug purchases from a wholesaler, buying by the package. The wholesaler then sends the manufacturer a chargeback for the difference between their purchase price and their sale price. When the manufacturer receives this chargeback, it doesn't have any information about where or how the 340B drugs were dispensed.

Middlemen in the 340B supply chain are also taking a cut, as they are throughout the system as a whole (as of 2015, more than 40% of patient spending on pharmaceuticals went not to drug companies, but to supply chain intermediaries<sup>17</sup>). One example: contract pharmacies, who partner with covered entities to dispense discounted 340B drugs to eligible patients. Around 30,000 contract pharmacies now participate.

Covered entities and their patients rely on these pharmacies to ensure access to needed medicines, but the growing power of contract pharmacies means they can charge increasingly high fees on each dispense. That means that some of the 340B savings aren't going to patients or providers – the intended beneficiaries of the program – but to shareholders at big pharmacy chains like Walgreens and CVS.



# O4

## Solution

The tech-enabled solution  
to systemic inefficiencies

## How multi-sided platforms are set to transform the business of healthcare

An innovative technological infrastructure that enables communication and enhances transparency can solve the drug channel's challenges, resolving the systemic inefficiencies that have made drugs unaffordable for the patients who need them most.

**That technological solution: the multi-sided platform.**

A multi-sided platform is built to connect two or more interdependent user groups, minimizing transaction costs in a market. It acts as a central mediator whose robust infrastructure enables direct interactions that would otherwise be impossible.

In our day-to-day lives, multi-sided platforms such as Uber and Lyft have fundamentally altered urban transportation around the world. Airbnb has changed the way we travel and explore new places, and Amazon has altered the retail landscape by connecting sellers and buyers. These are just a few examples.

Less visibly, but just as importantly, multi-sided platforms are transforming the business of healthcare, enabling transparency and efficiency

in a highly complex and fragmented market. A few examples include CoverMyMeds, SureScripts and Teladoc. These promising platforms are already helping weed out wasteful healthcare spend. Inspired by this vision, investment in digital health platforms soared 420% between 2017 and 2020.<sup>18</sup>

To solve the systemic inefficiencies in the drug channel, Kalderos created a multi-sided platform for Drug Discount Management. This is a pivot point for patients. We're building the infrastructure to make drugs more affordable for patients, and ultimately ensure more discounts directly benefit patients.

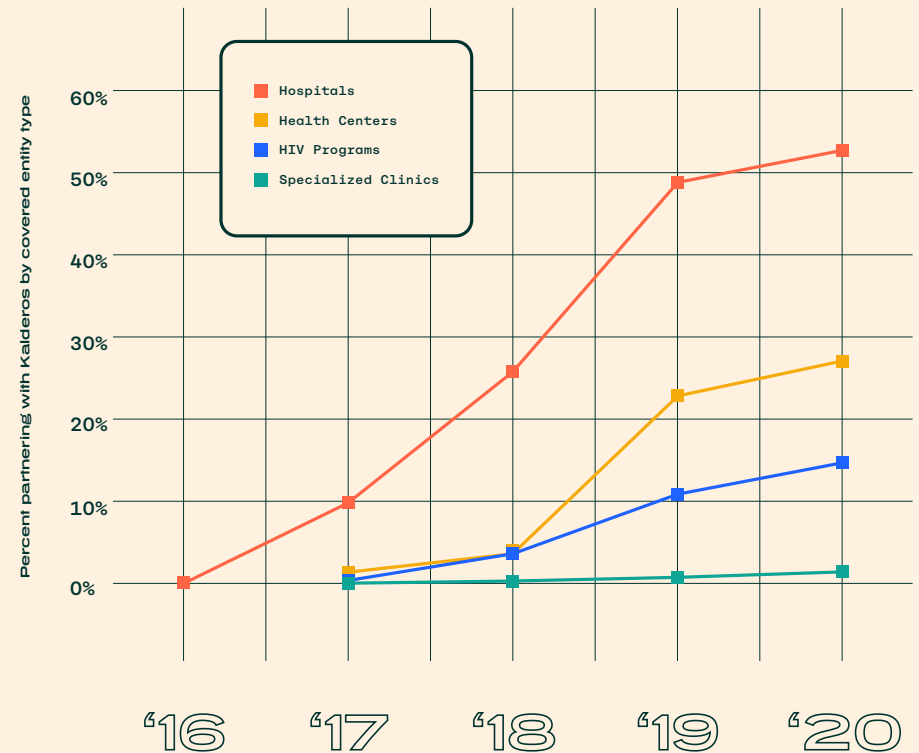
### The Kalderos platform utilizes machine learning, predictive technology and other tools from data science

The Kalderos platform is built with a blend of traditional and emerging technology, augmented

with machine learning and tools from data science. Using predictive algorithms to analyze proprietary data sets, this approach reveals powerful, actionable insights, not just about compliance in drug discount programs, but about the health of the drug distribution system as a whole.

This platform is already making an impact on the 340B space. One key insight that drove our approach from the beginning: because of data integrity and data compatibility issues, only 340B covered entities have the full picture on their dispenses. So, we went directly to our 340B partners to get their insights on more than half a million claims. With their assistance, we've assembled the nation's largest dataset of noncompliant discounts.

Our 340B solutions apply machine learning to these patterns to identify the complex interactions that indicate a likelihood of misapplied and noncompliant discounts. The predictive abilities of these tools are unlike any other organization's approach, enabling Kalderos to identify misapplied discounts that other solutions miss.



### Kalderos' fast-growing network of covered entity partners

Kalderos works with a rapidly expanding network of safety-net healthcare providers. The majority of 340B covered entity hospitals are now Kalderos Review users. As of 2020, we're also collaborating with more than 1 in 4 covered entity health centers.

Source: HRSA Office of Pharmacy Affairs; Kalderos Internal Data

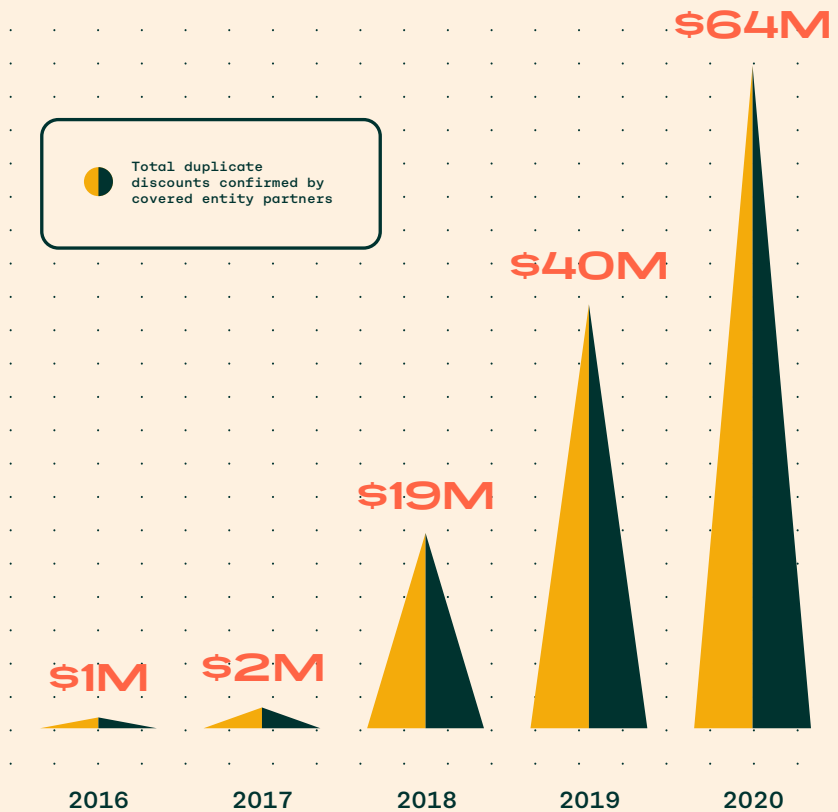


## For the Kalderos platform, strong stakeholder relations form a lasting foundation

Key to Kalderos' approach: supporting the needs of all stakeholders. The Kalderos platform is designed to connect and equalize relationships across the drug channel, bringing fairness and equity while balancing the needs of all stakeholders.

In developing our platform solutions for 340B, we came to the table with that same spirit of collaboration and support. We led meaningful conversations with every kind of stakeholder in the 340B program: covered entities, drug manufacturers, pharmacists, third party administrators, Medicaid officials, and, most importantly, patients.

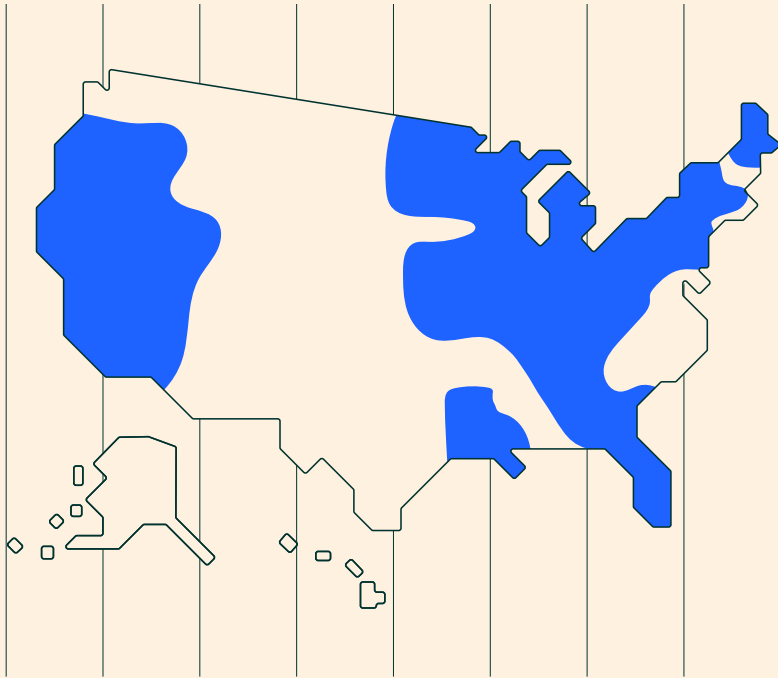
We continually make improvements based on input from our partners. Thanks to their honest and transparent feedback, we continue to learn more about the challenges in the system, and how to solve them – giving everyone the ability to focus less on administering a complex, fragmented system and more on the health of patients.



### Misapplied discounts verified by covered entity partners since 2016

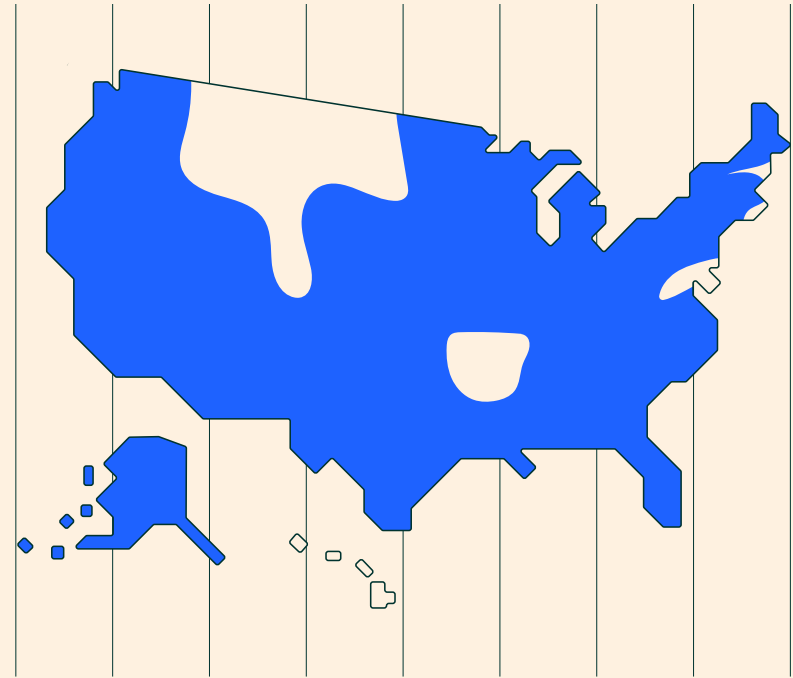
Since Kalderos launched in 2016, our covered entity partners have used the Kalderos Review tool to verify a total of \$64 million in duplicate discounts between Medicaid and 340B. Their efforts have an impact far beyond the dollar amount; by identifying why and where duplicate discounts happen, Review users are helping every stakeholder in 340B build more robust and sustainable systems.

Source: Kalderos Internal Data



2017

22 States



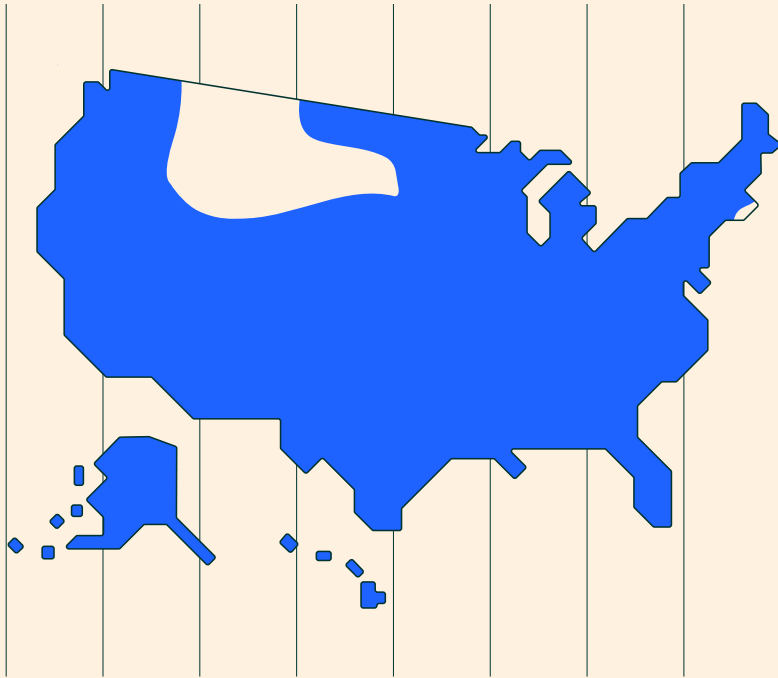
2018

40 States

**Kalderos has built relationships with Medicaid agencies in 49 states**

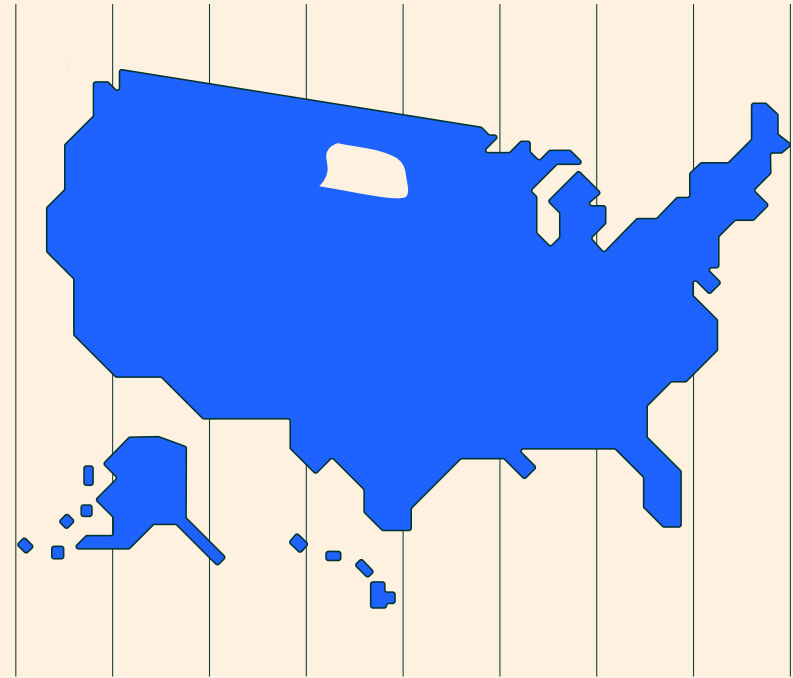
Kalderos works with states to resolve duplicate discounts between 340B and Medicaid. As of 2020, nearly every U.S. state (as well as D.C.) has collaborated with Kalderos to identify and correct misapplied discounts.

Source: Kalderos Internal Data



2019

47 States



2020

49 States

### Kalderos has built relationships with Medicaid agencies in 49 states

Kalderos works with states to resolve duplicate discounts between 340B and Medicaid. As of 2020, nearly every U.S. state (as well as D.C.) has collaborated with Kalderos to identify and correct misapplied discounts.

Source: Kalderos Internal Data



## How Kalderos platform solutions bring transparency, efficiency and cost savings to 340B

Today, Kalderos solutions are primarily focused on identifying and resolving noncompliance at the intersection of Medicaid and 340B, and giving drug manufacturers the tools they need to ensure they fulfill their responsibilities to both programs. Built on our first-of-its-kind multi-sided platform for Drug Discount Management, these solutions include Discount Monitoring and 340B Pay.

1. Discount Monitoring enables manufacturers and covered entities to work together to identify and resolve historical instances of noncompliance.
2. 340B Pay enables manufacturers, covered entities and Medicaid agencies to work together to effectuate 340B discounts compliantly and efficiently, granting visibility to all stakeholders in the process.

Kalderos' 340B platform solutions were built from the ground up to support the needs of every stakeholder in 340B, ensuring that discounts are paid accurately and on time. Through focus group testing and pilot studies, we've built a platform that is convenient, transparent and easy to use.

→ **7 in 10** providers said that: "Kalderos solutions enable collaboration with manufacturers on good faith inquiries"

→ **7 in 10** providers agreed that: "Kalderos has a helpful customer support team that understands my needs"

→ **2 in 3** providers said: "Kalderos makes my good faith inquiries workflow easier"<sup>19</sup>



When it comes to up-to-date information on 340B program audits, Kalderos is the site you want to rely on. I have found their platform to be user friendly and their attention to customer service is commendable."

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**Monica Rios**

Director of Social & Community Programs  
Frederiksted Health Care, Inc.

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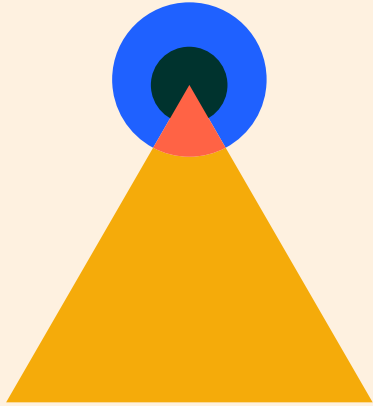
I was happy to learn that manufacturers, Kalderos and covered entities can support the intent to reduce / avoid / protect against duplicate discounts. They (Kalderos) are leaders in the field that wish to preserve the intent of the 340B program and ensure a health center is able to continue to provide access and affordability to the patients or communities they serve."

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**FQHC**

Pennsylvania

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# 05

## Outlook

What's next for the  
Kalderos platform, and  
the business of healthcare

## We are redefining how the business of healthcare performs

The endemic issues in the U.S. healthcare system are challenging ones. They're not going to be resolved overnight. But Kalderos is committed to building unifying technological solutions that bring transparency, trust and equity to the entire healthcare community.

In 2021 and beyond, we're bringing solutions and tools that will support other drug discount programs using the same data-driven, tech-enabled, transparency-minded approach that we brought to 340B.

Our company roadmap is built on a vision of replacing chaos and confusion with simplicity and efficiency, bringing healthcare's stakeholders together, and empowering everyone to spend less time on paperwork and more time delivering value to patients.

What that vision looks like in practice:

- Connecting all stakeholders to reduce waste. When communication is simple, streamlined and efficient, and essential data and record keeping is transparent to all, everything works better, and patients win.

- Simplifying the number of connections between stakeholders. Right now, the complicated chain of intermediaries hinders the flow of data and the flow of funds. But Kalderos' technological solutions can enable seamless financial transactions surrounding both prescription drugs and other healthcare-related goods and services, removing friction for providers, payers and patients.

## We are empowering healthcare to focus on patients

In 2020, Kalderos raised \$28 million in Series B funding. A few months later, Aneesha Mehta, a healthcare expert at Bain Capital Ventures, wrote in support of our vision:

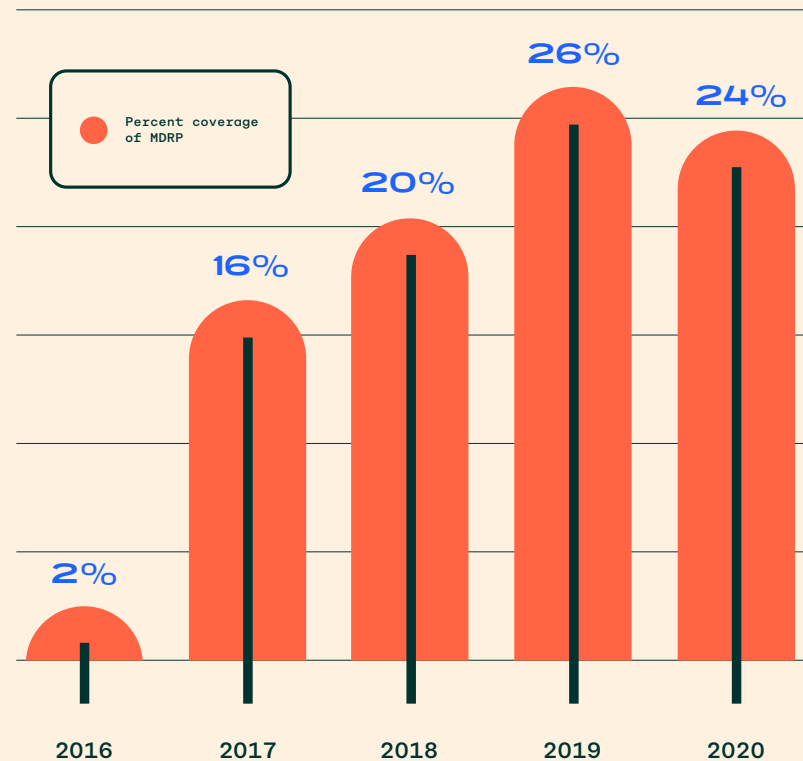
"Stakeholders have sought disruptive solutions to solve discount program challenges for years, yet nothing to date has solved the underlying transparency flaws. ... They are services that support single parties, not platforms that improve the whole ecosystem, and often they add rather

than subtract complexity as more players enter the space. We've all seen the benefits of platforms in other industries, and it's time healthcare innovators, and more importantly, patients, reaped these benefits as well. We couldn't be more excited to partner with Kalderos as they launch 340B Pay, bring transparency to drug discount programs, and work tirelessly to lower the cost of healthcare for patients."<sup>20</sup>

## We are scaling rapidly to execute on our goals

With the confidence of our investors behind us, Kalderos is scaling rapidly. Since June 2020, we've welcomed more than 65 new employees to the team, growing the company from 43 to 110. Our growth isn't just in numbers. We're also focused on building a bold, inspired, collaborative team and a joyful, results-focused company culture so that we can thrive in the long term.

Through every new day and every new hire, we get closer to executing on our big picture goal: redefining how the business of healthcare performs, so the patient comes first.

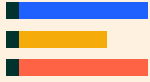


### Kalderos' expanding coverage of prescription drugs reimbursed by Medicaid

With rapid growth over the past 4 years, Kalderos now provides Discount Monitoring solutions to some of the top drug manufacturers. Our manufacturer partners now account for around a quarter of all Medicaid drug spend. We anticipate this dynamic trajectory will continue.

**Source:** CMS, State Drug Utilization Data; Kalderos Internal Data





## Supporting our 340B stakeholders in 2021 and beyond

In 2021, we're introducing even more provider-friendly features to our platform solutions for 340B.

Through our process of continuous feedback and collaboration with safety-net healthcare providers, we've stayed focused on ensuring that our 340B solutions are simple, easy and rewarding to use, easing the burden of compliance.

Based on provider needs, we're building out our 340B solutions to enable easier third party integrations, facilitate dispute resolution, improve provider cash flow and speed partner implementation.

The Kalderos platform is designed to serve as the foundation for other innovations. Our product roadmap is just the beginning; the value of a platform is its flexibility to grow, change and expand as the needs of the market change. We look forward to growing and changing too as we pursue our mission to redefine how the business of healthcare performs.

## Footnotes

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- <sup>2</sup> National Center for Health Statistics. "Therapeutic Drug Use: Prescription Drug Use." Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm>
- <sup>3</sup> "NHE Fact Sheet." Centers for Medicare & Medicaid Services. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>
- <sup>4</sup> Robert Langreth. "QuickTake: Drug Prices." Bloomberg. Sept. 16, 2020. <https://www.bloomberg.com/quicktake/drug-prices>
- <sup>5</sup> Bloomberg; see above.
- <sup>6</sup> IQVIA Institute for Human Data Science. "Medicine Spending and Affordability in the United States: Understanding Patients' Costs for Medicines." August 2020.
- <sup>7</sup> IQVIA; see above.
- <sup>8</sup> Amitabh Chandra, Evan Flack, Ziad Obermeyer. "The health costs of cost-sharing." NBER Working Paper Series. National Bureau of Economic Research. February 2021. <http://www.nber.org/papers/w28439>
- <sup>9</sup> National Bureau of Economic Research; see above.
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- <sup>11</sup> HHS Press Office. "HHS Finalizes Rule to Bring Drug Discounts Directly to Seniors at the Pharmacy Counter." U.S. Department of Health & Human Services. Nov. 20, 2020. <https://www.hhs.gov/about/news/2020/11/20/hhs-finalizes-rule-bring-drug-discounts-directly-seniors-pharmacy-counter.html>
- <sup>12</sup> Adam J. Fein. The 2021 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. Drug Channels Institute. 2021.

## Footnotes

- <sup>13</sup> Charles E. Grassley and Ron Wyden. "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug." Staff Report. United States Senate Finance Committee.
- <sup>14</sup> Drug Channels Institute, 2021 Economic Report; see above.
- <sup>15</sup> Drug Channels Institute, 2021 Economic Report; see above.
- <sup>16</sup> GAO Highlights. "340B Drug Discount Program: Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement." United States Government Accountability Office. January 2020. <https://www.gao.gov/assets/gao-20-212-highlights.pdf>
- <sup>17</sup> Neeraj Sood, Tiffany Shih, Karen Van Nuys, Dana P. Goldman. "Follow the Money: The Flow of Funds in the Pharmaceutical Distribution System." Health Affairs. June 13, 2017. <https://www.healthaffairs.org/doi/10.1377/hblog20170613.060557/full/>
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- <sup>19</sup> TechValidate Covered Entities Survey. Kalderos. January 2021.
- <sup>20</sup> Aneesha Mehta. "The Next Platform Frontier: How Platform Models Are Poised To Bring Transparency to Drug Discount Programs." Kalderos Blog. Sept. 9, 2020. <https://resources.kalderos.com/blog/the-next-platform-frontier-how-platform-models-are-poised-to-bring-transparency-to-drug-discount-programs>



Kalderos created the world's first Drug Discount Management platform, which uses sophisticated models and machine learning to resolve noncompliance in drug discount programs. The company's solutions include Discount Monitoring, which identifies and resolves historical instances of noncompliance, and 340B Pay, which allows providers of any size to request 340B rebates and manufacturers to verify and pay them through a third party payment partner.

Based in Chicago, Kalderos was founded in 2016 by a team dedicated to reducing inefficiencies in the U.S. healthcare system, empowering everyone to focus on the health of people.

Learn more at [kalderos.com](https://kalderos.com)