Primary Care Cures

Episode 125: AJ Loiacono

Ron Barshop:
Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

So we have half a million medical assistants in America and a large percentage of them work in primary care, but should we even call the medical assistants? Because if you think about the lie we've been telling these mostly single moms for decades is that they're going to be getting a job in healthcare, but seven out of eight, never handle patient care, but our transactional or cleaning or prepping rooms. And the one in eight, just cuffs and waves and rooms us, that's the extent of patient care for 85% of our day, the rest of them are doing intake or outtake, referral coordination, billing, coding, collecting, pre-authorizations and room prep, so janitorial. What a fraud our vocational schools are? Let's be honest and call medical assistants what they are in primary care at least, insurance clerks, in scrubs or janitors. They're dead end jobs with little or no upside. Most amaze are on Medicaid, they're working poor, mostly single moms, as I said, and we're talking about hundreds of thousands of jobs in healthcare.

Ron Barshop:

There's a moral regime with all that bloat, just to get paid, it's like wearing a hot fur coat in the middle of July in Texas, it's dopey, and it's unfair. The bigs own this nasty underbelly of endless perpetual middle class in primary care and I don't ever believe that bad people work in these giant carriers, but I do believe they'll do nearly anything to perpetuate the status quo. It's too rich of a status quo. And the primary care doc ends up seeing 8 cents on every dollar, if they're working for a system and up to 27 cents, if they're independent. Because they have to employ all these insurance clerks to get paid and they can retroactively owe every penny back if every I is not dotted and every T not crossed. Chargebacks on honestly performed work, it's a weakness and fear of every clinic, the fear of every doc dotting their I's really?

Ron Barshop:

Okay. So opt-out, direct contracting is the answer. I'm living in a future where we all win and recoupments can't wipe us out and medical assistants aren't allowed to. Opt out, join 25 million of those patients and at least 25,000 providers by my count, and that's just the people that have been on my show. There's a lot of people who haven't been on my show. Today's guest is in the

heat of the battle and he's saving employers a pharmacy spend of about a third off of where they were before they opted out. Welcome AJ Loiacono, to my show. He's the head of Capital Rx.

AJ Loiacono:

Thanks for having me, Ron.

Ron Barshop:

Yeah. So AJ, I'm glad I got to say that instead of Loiacono over and over again. Is that a Hawaiian name? What is that, men?

AJ Loiacono:

It's funny, I get asked that all the time. The origins are Greek and I guess parts Sicilian.

Ron Barshop:

I got it. Okay. Well, so we're not going to mess with you then. Hey, AJ, let's start off with asking a couple of questions about pricing. Pricing is not very transparent. How is your pricing compared to what people experienced before?

AJ Loiacono:

Yeah, I think, perfect starting point, which is, I think the problem many people don't understand with drug pricing is, we just don't understand it or can't see it. And I try and point this out all the time where people say, well, patients and consumers are incapable of understanding drug prices because there's tens of thousands of drug prices. And my quick response to this is when we walk into a grocery store, I have no difficulty, very quickly understanding what a fair price is, at the register. And I think if you had to compare this, and this is a statistic I use, the average grocery store has 60,000 SKUs, stock keeping units.

AJ Loiacono:

And in comparison, the average employer group has maybe 10,000 drug codes that they're managing in a population, but what's more important is people forget that we're naturally good shoppers. And so what is someone really concerned with is maybe the four or five medications that they may have or come into contact with and that's what they're shopping for. And so if I have to give an example here, is what we're really missing in the US healthcare system with prescriptions is really getting access to true prices. And this is what has held us back for far too long.

Ron Barshop:

So you benchmark your pricing a different way than most PBMs do. Tell us how you operate?

AJ Loiacono:

Yeah. I think where we want it to start with is how does any efficient market operate? And efficient markets operate when buyers and sellers freely communicate on price. Let's use my grocery store. If I'm checking out in the grocery lane and I'm seeing the person in front of me have the same dozen eggs they're checking out with and they're paying $4 for that dozen and I go

up with my eggs and now it's $16. You wouldn't just let that go. You would be like, wait, why are my eggs $16? And this is what we decided to fix, which is, it's not just the source price, we wanted to make sure everyone has the same price because what people also not understand is we work in a system where pricing is artificially manipulated, where there's a winner and a loser decided every second of every day, millions of times over, which is are you today's winner or loser on pricing?

AJ Loiacono:

And it's not because the drugs are changing price, I want to point this out. The supply chain of drug pricing is incredibly stable. So it's not that well, the drug price was four now it's 12. It was 18, it's six. That's not how it works. So when we had to reimagine the entire supply chain and get to fair, stable, unified pricing, what we wanted to start with was one, what's the source price? So we do something different. We use NADAC pricing, national average drug acquisition costs. Why? Well, it's provided to us by our friends at the federal government. It is provided by CMS. It is representational of drug reporting of acquisition costs by retail pharmacies. So they report, what did I actually acquire the drug for? And this is a fair benchmark. It's not something that is make-believe, highly inflationary and manipulated. And so what we wanted to look at is let's start with a fair standard that comes to us from the government.

AJ Loiacono:

And this is important. We decided we can't change the price as a PBM. Now, this is important because all other PBMs have the right to change price, they can change price through Mac, through different rates. And we said, no, we're going to use this as a standard. And then the second thing that we did that was different is we said, everyone gets the same price. Back to, Hey, I work for a big employer or a small employer or a midsize employer, why are people getting different prices for a drug that isn't changing price? So the last part of this is we wanted to provide a fair market for the pharmacist and the patient. And this is important, you want to have fair reimbursement to the pharmacist, no one's here to punish the pharmacies. And the second part of it is you want the pharmacy to signal value.

AJ Loiacono:

So we use NADAC pricing, but we also work with our pharmacy partners and say, "Hey, do you have a better unit price that you would like to provide the people coming into your store?" And it sounds like such a simple idea, like, hey, it's my inventory, let me set the price, like band-aids or deodorant in my pharmacy. Why can't I do the same with drugs? But in the US healthcare system, the pharmacists are beholden to the PBMs and carriers. They set the price and not to benefit the inpatient or plan, but to create more profitability for them. So let me pause and we can go over these different parts.

Ron Barshop:

Yeah. I want to talk about the pricing title you said. Because I don't think most listeners know what that means, but the bigger question is can you, as a PBM, not send or mail drugs directly to the consumer, or do you have to go through a retail pharmacy?

AJ Loiacono:

So we as a PBM, we're agnostic. And what this really means from a fulfillment channel is we let the plan and or the patient decide how they would like to receive their medication. And I think this is an important thing to remember because some plans say, "Hey, I would like people to go through mail order. Some people would like people to have choice." So we don't fight our end customer and client on this issue. So if someone wants to fill their medication at their local independent pharmacy, we support that. If someone wants to go and have it through mail, they can. So I think choice is a big part of this.

Ron Barshop:

Okay, I got it. So they can get the drugs directly through you and you can mail them to them. Can you send it to them in a PillPack or does it have to be in the normal containers they were just leaving them in?

AJ Loiacono:

Well, I think here's the great part about our model. If someone wants to use PillPack, they're part of our network. We don't preclude anyone from not being able to fill anywhere. Because this is the part of an efficient marketplace, buyers and sellers communicating. So if I want to purchase a good at store, A, B or C, I'm not letting someone be held back or restricting that choice. I think the key here is to say, here are the prices and here's how you can access your medication. Some people may choose based upon speed. This is across the street from where I live. Some people may say, I know that person, he has been serving my family for 20 years. Great. Someone may say, I like the convenience of having it mailed to my home address or even delivered. And so that's the future of healthcare, but it begins with stable prices that are publicly communicated, not manipulated and let the consumer in the plan make these decisions.

Ron Barshop:

So tell us a little bit more about this benchmark you've mentioned.

AJ Loiacono:

Yeah. I think this is an important area of focus because every single PBM with the exception of us use AWP pricing, it's their default pricing, average wholesale price. It comes from a company Wolters Kluwer, Medi-Span. And unfortunately, it is an inflationary standard. And so we decided to do a study a year ago and submit it to AMCP for review. And basically we said, "Hey, what if we took the top 1200 generic drugs?" This represents over 90% of generic utilization and spend in the United States and said, "What are the prices doing if your source price is AWP, average wholesale price, which every other PBM uses, and it's gentle inflation, it's going up approximately plus 1%, that doesn't sound too bad, that seems like reasonable price increases. But the reality is if you're using NADAC pricing, over that same five-year period, it's not inflating plus 1% it's deflating 50%, half off. And here's the problem, is employer contracts don't have a 50% discount over this period of time. They're lucky if they're picking up one or 2% contractually.

AJ Loiacono:

And so when you use a pricing source that you can't change, it's reported by the federal government, through retail pharmacies participating. And I always like to point this out. People

say, well, NADAC pricing isn't perfect. I go, it's not perfect, but it's light years better than AWP. Do you want to be in a contract where your generic prices are inflating or do you want a pricing standard where every year you're benefiting from deflation? And this is a great starting point to create alignment. We talk about this all the time in our companies. It's not just about pricing, we want to get away from pricing, pricing settles itself in every market. I don't care if you're buying sneakers or gasoline. When you begin to transmit and publicize price, people understand what fair prices are, but what you want to start focusing on is how do I help the patient, how do I help them manage their condition? How do I get to better outcomes? And how do I help them contain costs in this process? You can't do that if you're already starting with a show game.

Ron Barshop:

So this other pricing you mentioned, tell us what that means.

AJ Loiacono:

Average wholesale pricing is a mystery. I got to be honest to you. I don't know where it comes from to be fair.

Ron Barshop:

But what about the one you use? What does that, [inaudible 00:12:58]?

AJ Loiacono:

Yeah. We use NADAC national average drug acquisition cost. It comes from CMS, the federal government, and it is provided to us again because it's a reflection of acquisition costs, what pharmacies are purchasing their drugs for roughly. In comparison AWP, which every other PBM uses, it's a jumbled mess. I truly can't understand where the pricing is coming from back to the study we performed. If we're a reflection of acquisition cost by the actual pharmacies and generic drugs are deflating 50% over the last 50 years and their standard is up 1%, how does that even mean? I don't know where they're getting it from. And to be honest, we never will. And so that's not really our responsibility. Our responsibility is to provide a fair benchmark of pricing.

AJ Loiacono:

And then also we allow the pharmacies to provide a lower price. So it could be their cash price, usual and customary price, which is special offers they may have, or they may directly through us demonstrate value and say, "I know you're not going to be punitive. So if I give you a lower price, you're not going to take that profitability, keep it for yourself and charge the patient in the plan more money." And this is so important because this is what's been missing in healthcare, specifically in pharmacy benefits for 20 years.

Ron Barshop:

So are your customers TPAs, are they employers or benefit advisors? Who are you talking to?

AJ Loiacono:

Sure. So I think you have to think and answer this in two parts. The first part is who are the customers of Capital RX? So these are employer groups, they're public companies, private

companies, they're municipalities, they are unions. And we work with them on managing their pharmacy benefit plan. The other area of customers we have is we do work with some health plans, where they utilize our pricing framework and our systems and solutions to help them manage their own benefit programs for their members. And this is becoming more and more of a fast growth marketplace for us, because I think people are seeing the incredible results from our system and our solution.

Ron Barshop:

Got it. And how much are you saving customers when you calculate the numbers?

AJ Loiacono:

It's interesting, I like to use hard data here. So we just completed our quarter over quarter solution summary. So we took our entire book of business of people that were pre and post on our platform and in Q1, so this is Q1 compared to Q1, between the plans we saved 27%. And that is a huge number of savings. And these are hard dollars. I always want to point this out. This isn't inflation adjusted, which says, well, there was 5% inflation, so really it was 22% savings. This is PM, PM. This is patient level spend. So it's per member, per month looking at what the cost pre and post, exactly what they were. So this is an actual cost reduction. I can't tell you how many times I heard in the industry someone said they were promised 20% plus savings. And the following year, their trend was positive three or 4%. And people would be like, well, what happened? And people would say, it was inflation, it was drug mix. But here it is. Let me tell you the truth to drug pricing in the United States.

AJ Loiacono:

Your drug pricing, outside of more members entering your plan should be negative every year. And people will be like, "That's ridiculous, drug prices go up." And I go, "That's not true at all." And so if you were to look at brand drugs, like brand specialty, the price of the gross, the list price goes up every year. That is true. But the net price, if you read any of the pharma reports is the net price is negative. It's going down. So we call it gross to net in pharmaceutical. So the brand drug prices are decreasing one or 2% each year. You continue to see this price erosion. So brand drugs are going down. I just gave you the study that generic drugs are massively deflating. So if brand drugs and specialty drug prices net are deflating and generic drugs are deflating, why is every employer group outside of our book of business going up? The industry averages are plus 3%. And you could look at any PBM or carrier. It's usually what they're talking about. So where's that 20% plus Delta, it's in someone's pocket.

Ron Barshop:

Yeah. So that's the PBMs that are not fully disclosing like you are, that are picking that up, I suppose.

AJ Loiacono:

Well, if you think about it, every employer, PBM contract, outside of us is horribly flawed. And I point out, what are these major flaws? Well, the first thing is there's not a single drug price mentioned in a PBM contract with an employer. It's a description of pricing. Your drug will be an average over a year and a category based upon classification and DAW handling, that the

average will not exceed blah, blah, blah, blah, blah. And the problem with these discounted descriptions is they're not prices because they just don't want you to see price. Because to my point, once you understand price, you can start negotiating off of price. You can triangulate off of price. You can be like, well, wait, this is not a good price. And so the first flaw in employer contracts is they have no price. The second thing is you have what we call multiple ledger reconciliation. You can't see what's going on in the transaction, the pharmacy has a reconciliation, which is what the PBM pays the pharmacy.

AJ Loiacono:

The employer has a transaction, which is what was the employer charge? And the buy in the sell side, because the buy-side is the employer group, the sell side is the pharmacy, never communicate with each other and they're not on the same ledger. You can't see what's going on. So the mystery in the middle is what the PBM is keeping and they separate it. So there's flaw number two. Flaw number three is the way these contracts are constructed is that a PBM could hit whatever performance guarantees are in it, but it doesn't mean your pricing is going down or your service is better for your members or the outcomes of the patients are improving. And this is an auto fact of a system that's 20 years old. We need to shift the narrative from the Hocus Pocus of having drug prices in descriptions and performance metrics that mean nothing to translating it to real risk, real performance and real outcomes and service metrics. And that is what we're trying to pull the industry towards. And thankfully, people are responding.

Ron Barshop:

So you're talking to employers, are they able to negotiate with you this price range or this discount, or is it because you're already saving them so much, is that non-negotiable?

AJ Loiacono:

Well, it's not so much, we always want to point out is that if you're not making any money on fulfillment and what does that simply mean? We're not making money, any money on the drugs themselves, back to it's the same ledger, everyone can see all the transactions, so there's no middle part that's missing. And so what you're saying is here are what the price is, the real prices are, and they don't change every day. And all of your members get the same price. All of our customers are getting the same price. And the only time the price change, is if there's an update, and this is important because what you're setting the stage for is you really don't have to negotiate anything different. What we're saying is turn us on and you're going to see a massive improvement over where you were this time last year, once you have it started.

AJ Loiacono:

And I think this is where we've done an incredible job where the proof is in these metrics, where we've never lost a client, and we're going into our fourth year of operations. And I always point this out, how could you not lose a client? And I'd be like, because we're delivering on the promise of lower savings, better service and improved outcomes. And so, back to the negotiation is we do a pricing analysis. So we basically say, this is what your pricing is going to be under the new system and there's going to be additional savings through improved patient care, as well as reduction in what we call the velocity or proliferation of high cost drugs. And people would say, "Well, does that mean you're restricting drugs for people, they have a worst experience?" And

the answer is no, we're not restricting drugs, that's not the point is, we're educating the patient in real time.

AJ Loiacono:

So this is something that we do an incredible job compared to our competitors is we resolve presently every single client member issue in under 54 hours and counting, and that is light speed in this industry. And I want to get it down even further, and that's through our system and performance, but more importantly, we have lower prior authorization approval rates. And people would be like, so you're saying, no, I... No we're educating the patient, we're making sure that they should be taking the medication, but we have the highest satisfaction scores. So when we look at our call center, we have the highest customer stat scores. And when we look at our client level customer stat scores, we have the highest in the industry there as well. So our point is you can provide better oversight, better experience, and it's going to come through in the satisfaction, but it doesn't mean you're basically pushing out the most expensive drugs at the fastest pace possible, that's not what healthcare is.

Ron Barshop:

Well, congratulations on those stat scores. AJ, whose responsibility is it when a patient is on a specialty drug to migrate them over to a generic drug that works just as well, that's dramatically cheaper?

AJ Loiacono:

Sure. So when you say specialty drug, you're in an interesting category, so it could be a biologic or something in that category. So we're starting to see the emergence of biosimilars or lower cost alternatives in those therapeutic categories. I think oftentimes what you're trying do is you're trying to get to the patient many times before they're on that therapy, because if someone's responding well to a therapy, you don't want to take them off, regardless of cost, I want to be fair. I genuinely believe that the vast majority of physicians in this country believe in doing what's right for the patient. And if someone is responding appropriately and well with the therapy, leave them on it, however, should that drug turn generic, and in this case, you're saying specialty, let's say it's a biosimilar. You can now say you have this opportunity.

AJ Loiacono:

And we always want to make this clear, it has to be lower net cost. So it's not just list price is cheaper, it's the lesser of both list and rebate because sometimes there are drugs that enter the market that are still not as competitive as the brand drug, but remember we don't make money on drug prices and fulfillment. So what we're here to make sure of is people understand true net cost. So in the first example that you're giving, there's a generic available, is it truly lower on a net basis? Yes or no. And no one typically answers this question. The second thing that you're referring to, is there an alternative therapy that is not an AB rated generic or something that's off patent, that's being replaced as a biosimilar. And in that case, you can introduce the idea to the patient.

AJ Loiacono:

And many times the patient has never been educated. And so what we use is a combination of messaging through our systems, so this is through mobile applications in our patient portal to say, "Hey, by the way, did you know that this therapy may save you money as well as you may consider it, but you have to go back to your physician or nurse practitioner." And this is so important because I always want to make this clear, we could tell people what's available and educate them, but ultimately, it has to go back to that medical professional to make that choice with their patient.

Ron Barshop:

Well, and it's also complicated by self-insured employers are the ones that are saving the money, not the employee.

AJ Loiacono:

Well, and I think sometimes you're seeing savings because let's be fair, the vast majority of employer groups have a deductible. So most employees are going to feel that cost at the start of the year. In addition, a lot of plans of co-insurance they continued to feel higher costs regardless of time of season. So I think when we look at this model, it's important to always remember, you should be providing this information in the alternatives, but at the same time, you can't force anyone and you always have to remember that the patient now can benefit from this as much as the plan.

Ron Barshop:

Yeah. So AJ, how do people find you if they want to reach out to you?

AJ Loiacono:

Sure. If you want to reach out to us, you can go to our website, capitalrx.com. We obviously would love to hear from you, you could also email us info@cap-rx.com. And so if someone wants to send us a note or learn more, you can visit our website or send us an email directly, please.

Ron Barshop:

And before I sign off and ask my final question, I'm trying to get a head count of how many are playing in this direct contracting space. What is the head count that you have for patients now? What do you think it's going to look like in two or three years?

AJ Loiacono:

As far as folks that utilize our services today?

Ron Barshop:

Yeah.

AJ Loiacono:

Yeah. And so today we service, in this calendar year, close to 500,000 lives, going into next year we hope to be over a million.

Ron Barshop:

Well, this is great because a four year old company can hit a million, four or five-year-old company can you hit a million with a much cleaner business model than the old traditional PBMs. Kind of nice.

AJ Loiacono:

Well, it did come with a lot of hard work and an immense investment in our technology and software solutions, so.

Ron Barshop:

Well, good on you AJ. So what is, if you could fly a banner overhead your messaging for America?

AJ Loiacono:

The message that I have for America, specifically the employer's side, is make your PBM accountable for the first time, make them bear the risk, do not accept the status quo, do not go the same direction with the same choice you've made time and time again. And I think many times they need to take a moment. And I want to be fair to the heads of HR, they are so busy. They're dealing with everything from salary to stock, option programs to dental, medical, take your pick. And I understand it. But pharmacy benefits is the fastest growing cost segment of healthcare, and they need to ask some questions and they need to have some fresh ideas. So my message very simply is do not accept the status quo, hold your PBM accountable and give us a call at Capitol RX.

Ron Barshop:

And it is fresh ideas because the largest PBMs in America are all owned by insurance companies and vice versa. So giving an upstart at new trier, fresh breath, for your own company is going to save you what looks to be at least a third off your pharmacy spend, easy money. All right. Well, AJ thanks for your time. I'm going to follow up with you again in a couple of years when you hit way past a million and we're going to celebrate that. Okay?

AJ Loiacono:

I appreciate it, Ron. Thank you so much for having me today.

Ron Barshop:

Thank you.

Ron Barshop:
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