Podcast #115: Dissecting the PBM Model with Karthik Ganesh

John Marchica:

Welcome to season four of Health Care Rounds. Here, we explore the vast and rapidly evolving healthcare ecosystem, with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including, improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy in work. I'm John Marchica host of Health Care Rounds. I'm also the CEO of Darwin Research Group, and Faculty Associate at the Arizona State University College of Health Solutions. Please, don't forget to rate and review us wherever you get your podcast, and send your questions, comments, or ideas for Health Care Rounds to Podcast@darwinresearch.com. Let's get started.

Kim Asciutto:

Karthik Ganesh is the CEO at EmpiRx Health, the industry's only value-based PBM, with a clinically focused in tech enabled approach, to bending the RX cost curve. Prior to EmpiRx Health, Karthik was the founding Operations Leader to CareAllies. Karthik is a senior healthcare executive, with a solid track record of comprehensively scaling, transforming and maximizing value, at tech enabled health service companies, while driving dramatic before and after results, across all facets of the organization. Karthik is recognized as a thought leader on healthcare, leadership and resilience. He is a published author, and has been featured in leading industry journals.

John Marchica:

Karthik, welcome. I appreciate your coming on the show today.

Karthik Ganesh:

Thank you.

John Marchica:

Before we get into your company, the first thing I'd like you to do is, walk us through the traditional PBM model, it's place and benefits, how they make money. Go through it slowly, because I think that drug pricing is one of those things that can be very complicated, and that people even in healthcare, don't really understand why they see the price of certain drugs going up at a certain rate, or even have any connection to the cost of drugs. So, I'm going to give you wide latitude for 5, 10 minutes here, to just go slowly, walk through, pretend I know nothing about healthcare, and you're going to explain to me that the traditional Pharmacy Benefit Management Model.

Karthik Ganesh:

Sounds good. What I found very intriguing about that question was, you went to Pharmacy Benefit Management, and you went straight to drug pricing. If I didn't tell you I was in the PBM industry, and John, I told you, "Well, my industry has historically and continues to focus on two things, volume and arbitrage. Buy for X, sell Y, and figure out how to make some money between the X and the Y," right?

John Marchica:

Right.

Karthik Ganesh:

John, what industry do you think I belong to? You would have said, "Well, it sounds like retail." We're supposed to be healthcare benefits. We're supposed to be healthcare. But, the industry for the longest time, has been about volume, and has been the fixation with volume-based everything, because it really came down to this notion of, at the end of the day, it's all about drug pricing, and it's about costs. It's really about trying to figure out how you scale, and gain more volume, and as a result, get deeper discounts. But, the question then comes back to, discounts off of what?

Let's say you wanted to travel from Phoenix, up to your lodge. Let's say I want to do the exact same thing. We don't have a car, and I decided I was going to buy... I was going to go and get a Honda at a 10% discount, because the 2020 models are going at a 10% discount rate now. You decided, "You know what? This is a great opportunity because, my local Mercedes dealership is giving me a 40% discount." So, you went and got a Mercedes at a 40% discount. This industry has loved the fact that your 40% must be better than my 10%. Even though at the end of the day I ended up spending less on my vehicle than you did, I still got your large, perfectly fine, and a very reliable car, right?

John Marchica:

Sure.

Karthik Ganesh:

That's the fundamental place where the PBM model is broken down, and it continues to break down. This notion of, at the end... So, very simplistically, you can call it a traditional model, you can call it a transparent model. Whatever the flavor of the month is, whether it's a black box or a glass box, whatever that flavor is, it continues to be about volume. No different from the challenges we've encountered on the medical side of the house, where there's been a very distinct push from this volume oriented fee for service model, to finding a more viable alternative. PBMs have been about volume. Everyone who comes out and says, "Well, I'm not a traditional model, I'm a transparent model. Look at my transparency." They're basically putting another coat of paint on a model that continues to be about volume, and arbitrage.

Then, you throw in the fact that volume gives you, whether it gives you more discounts, or it gives you more of a rebate check, it still is volume. It's not healthcare. You and I are both smart enough, you've been doing this for a long time, John. You and I both smart enough to know that, just getting more drugs out there isn't improving healthcare outcomes or reducing costs, but that's the volume game.

John Marchica:

That implies then that, let's say an Express Scripts which has quite a few people under... I should have this number at my fingertips, how many people that they have managed, is getting better discounts or better rebates than let's say a startup PBM or a smaller regional TBM, because of the volume.

Karthik Ganesh:

Correct.

John Marchica:

So, back to the pricing, and I know I'm kind of fixated on this, but, I want to understand, fully understand the drug pricing model. So, you have an average wholesale price, right?

Karthik Ganesh:

Mm-hmm (affirmative).

John Marchica:

Or a wholesale acquisition cost.

Karthik Ganesh:

Correct.

John Marchica:

Then, the PBM will get either a discount or a rebate or both, off of what... Walk me through the spread model just a little bit.

Karthik Ganesh:

Think about it very... If we take the PBM out of it, John, just think about retail in general, when you think about that model. They've got a captive membership pool of X millions, and millions, right?

John Marchica:

Right.

Karthik Ganesh:

As a result, they're able to negotiate, have a conversation with the manufacturer, and negotiate deeper discounts. As a result, by virtue of giving the manufacturer greater access to market share, they're able to negotiate a rebate on the heels of that as well.

John Marchica:

Okay.

Karthik Ganesh:

That is the entire model, in a nutshell. No different from whether you were to go into a large Costco or go into a Walmart, or any one of these places. If [inaudible 00:07:36], I've got better buying power. As a result, I'm going to get this extremely cheap. Then my question is, the question at that point quite frankly, is as simple as, what is my markup? That is the spread.

John Marchica:

Got it.

Karthik Ganesh:

Arbitrary, right? I'm buying for X I'm selling for Y, and how much of that delta am I going to keep? They would keep all of it, but then you've got the benefit advisors in the middle of it saying, "Well, we really need to understand what the delta looks like. Let's squeeze this bubble a little bit more. So, you've got to share whatever the delta is." What they buy does not need to be disclosed. All that needs to be disclosed is what they sell. Let's say I buy a drug for 100 bucks. There's no reason to disclose the fact that the drug was bought for 100 bucks. What does get disclosed is, "Well, I'm going to sell it to you for 120 bucks."

Now, on the open market, and this is where the beauty of the PBM model does come in, if you were to go direct to manufacturer as an employer and try buying it, it'd probably cost you 200 bucks to buy it. So, the PBM is drawing down on that number, but based on their girth and their size, they bought it, picked it up for 100 bucks, they sold it for 120 or 130.

At that point, organically, by virtue of just playing middleman in an arbitrage model, the PBM just made $30. Now, it actually is good for the other constituents and for the other stakeholders in that ecosystem, because the employer just got a $200 drug for 130 bucks. You've got the member, or the employee, or the patient, who essentially, if they had gone direct to manufacturer, would have spent $200. They basically spent no more than their copay, or whatever their plan design allowed them to spend. So, they probably spent 10, $15, whatever, and they got this drug for 10, or $15, based on the negotiated rate with their employer. It's a win-win for all of the others.

Karthik Ganesh:

But in that model, fundamentally, the PBM is incentivized to get more of those $100 drugs out for two reasons. One, they're making $30 on every one of those $100 drugs being shipped out. That's one reason. The second is, by virtue of telling a manufacturer, "I've got all of this. I've got..." Let's say it's a manufacturer that's dealing in, let's not pick names here, let's just say the dealing in Statin as an example. So, you've got a PBM saying, "Well, I've got..." Let's say I've got, I wouldn't even go the Express Script route. Let's say I got 10 million lives. On an average, one would think about 30% of them, just given what we see from a market standpoint right now, and the health of our population standpoint. 30% possibly have some sort of a cholesterol problem or are cholesterol wannabes, primarily because you've got these... The WHO says, one in three Americans is clinically obese, right?

You're looking at a 10 million number, you're looking at 30% of that number, about 3 million. 3 million is approximately the number of folks that might need a statin. By virtue of my formulary, and working with the employer and plan design, I'm going to figure out a way to get X% market share towards you. For every percentage point of market share that I can gain across that 3 million continuum of patients, my rebate check from you escalates appropriately. So, that's where the misalignment comes in, because it continues to be about how many of these $100 drugs, because I've got multiple revenue sources, if I'm a traditional PBM, multiple revenue sources to capitalize that $100 drug on my balance sheet. My acquisition costs might've been 100 bucks, on my balance sheet, it's probably worth about 250, 300, all in. So, that's the model in a nutshell, and that's the volume orientation of the model in a nutshell as well.

John Marchica:

So, PBMs would argue that, the value that they're creating, is the fact that they have this purchasing power. And the value that they're creating-

Karthik Ganesh:

Absolutely.

John Marchica:

... Is just being able to, instead of that $200 price tag, you're only paying 130.

Karthik Ganesh:

Absolutely. We should completely agree that that is tremendous value, no different from the fact that Costco's buying power allows us to go and buy more and more. Let's say I have a $200 budget at home for my groceries. I could go to a Target, be very targeted, go and pick up my $200 worth of stuff, and get out of there. Now, I go to Costco, it's got more stuff at all these discounts. I just realized I'm spending 500 bucks each month, because I'm a kid in a candy store, right?

John Marchica:

Right.

Karthik Ganesh:

I can just grab all this stuff. But, I got a discount on all of those things. I got a deep discount. That's where, the notion of value, this is where the industry centricity comes into play. PBMs are absolutely... If the PBMs were a retail venture, they are adding tremendous value, by essentially allowing scale and size, to somewhat neutralize what drugs cost. But, we're in healthcare. So, when I qualify... When we look at the qualification of value, what would this whole notion of, and this is not just PBMs. We see this in the plan side as well.

But, what this whole notion of these entities behaving like retail companies, what that has done is, you've got employers who feel the health of their employees, and the cost of their benefits, is an either or situation. I can't get my benefit provider to really help me improve health outcomes, and put more programs, and focus on my employee population, while also giving me an incredibly great price point, and driving savings down. They feel it's an either or situation. It shouldn't be.

Now, let's take the other example of the other place where... Let's go with the retail construct again, for a second, because value in retail could be construed in two ways. We took the Costco, Big Box, and again, I'm a huge Costco fan. There's nothing like Costco.

John Marchica:

Yeah, me too.

Karthik Ganesh:

Costco is up there. Then, you've got Amazon. I'm assuming you're sitting in Phoenix in the midst of a pandemic, if you weren't a Prime consumer, you're a Prime consumer now, right?

John Marchica:

Right.

Karthik Ganesh:

So, when you go on Prime, you feel like the price point is appropriate, it feels low enough. That's one. You've got a lot of options, so you know your price point is going to be appropriate to pick. That's one. Two, your shopping experience is seamless, and they deliver it within 48 hours at your doorstep. Three, if you don't like what you got, they make your return incredibly seamless.

John Marchica:

Right.

Karthik Ganesh:

That's value. Now at that point, is your first question, "Well, I really don't like the fact that Bezos is making a lot of money off my back. What's the acquisition cost of... He's selling me diapers for X. What's the acquisition cost on that 20 pack of Pampers from China? How much did the warehousing cost him? What was the last mile cost for his trucks that came, or his delivery vehicles that dropped it off at my doorstep?" Do you care about any of that?

John Marchica:

No, of course not.

Karthik Ganesh:

You care about the value that that entire experience gave you. When I think about value in healthcare, it really comes down to, it's a tripod. It's clinical, it's financial and it's service. How do we... As an employer, how can I get my employees the best possible benefits, driving the best possible health outcomes? Clinical. How do I get deep savings year over year and not just have my benefit vendors shrug and say, "Costs are going up, dealing with it." How do I get the best possible savings for both myself and for my employees? Why should I be subjected to subpar service levels? Just because the industry's become okay with them? That's value.

If I can get a benefit provider to do the right things for me clinically, and not just because they say they're doing the right things, to make the right things auditable and show it to me on a spreadsheet, demonstrate to me that they're saving me money year over year, not saving me money because they said they saved me money, saving me money because my pocket book says I'm saving money, or my balance sheet says I'm saving money. Then, give me the kind of service that I deserve. Frankly, because I am trying to offer healthcare to my employees, the only way they are going to utilize any piece of it, is because they're a patient. Treat me appropriately, because I am actually helping. I'm doing the right thing as a human being. That's value.

John Marchica:

Right.

Karthik Ganesh:

It's a foreign concept, it continues to be a foreign concept, one, within the PBM space. Two, I believe in the broader healthcare space, it continues to be a bit of a challenge, and the adoption is spotty at best because, it continues to be a healthcare concept. It continues to be payers and providers. Payers telling a provider, "I'm going to squeeze you via a value based contract, and let's figure out how we work your fee schedule accordingly." Who's holding the payer accountable for a value-based contract? No one is.

John Marchica:

Right. Well, theoretically, I guess the employer could be, right?

Karthik Ganesh:

Could be, but they're not. Because, no one has educated the employer on the fact that these are not either or decisions. If the employer were to tell the payer or the PBM, "Guys, you're going to prove to me that you're taking care of my employee base clinically, and I'm going to have my consultants audit you for clinical appropriateness, to make sure you're focused on the health and wellness of my employees. Because for me right now, midst of the pandemic or not, and especially in the midst of a pandemic, not only am I dealing with absenteeism issues, but I'm dealing with very fundamental presenteeism issues, because people are at their desks, they are seemingly productive, but are they truly effective?"

"Because, their minds are always someplace else. They're either worrying about their family members, they're worrying about the little death ticker that's showing up on CNN, they're worrying about this person they saw at the local grocery store, who didn't wear a mask. Well, did he spray on me? Did I get anything from him?" Whatever the case might be, presenteeism is a factor. As an employer, I should be demanding, one, to be sold value-based benefit. And two, for the value based benefit to be transparent. That's where I believe transparency becomes important.

If you're telling me you're doing right by me clinically, prove it. If you're telling me you're doing right by me financially, prove it. If you are telling me that you're going to service me the right way, prove it. If you don't... And I am not going to accept as an employer, your slacking off on any one of those three legs of that stool. They're all equally important, because if one of them breaks, I can't sit on that stool.

John Marchica:

Right, right. So, your thought is that, at least today, that the employers haven't caught up? I would imagine some of the largest employers, that they've got to be thinking... They're certainly thinking about the cost curve, right?

Karthik Ganesh:

They're thinking about the cost curve, and this is where they absolutely are. This continues to be... If we go back, take every single president that's tried doing something about healthcare in this country, John. We have consistently focused on the fact that healthcare is about cost and access. So, you're right. As an employer, they're thinking about the cost curve. As an employer, they're providing that access. But, cost and access are two things. They're not all of it. What if we say, healthcare was supposed to be about cost, access and value. Because, cost doesn't equate to value by itself.

John Marchica:

Sure.

Karthik Ganesh:

You could go and buy something that's extremely cheap, and it's going to pretty much last you two days, and you're done with that. It has no lastability to it. Access by itself, just because I can go and buy something, doesn't mean it's a high quality product. It doesn't give me value. Healthcare should be about cost, access and value. The value component of it continues to be something that employers are not educated on. This is where as an industry, and I'm looking at the industry broader than PBMs, as an industry, we haven't created the consumer or the buyers imperative, to have a value oriented conversation. And why is that? Because, by not changing the paradigm, by not disrupting ourselves, we're all making enough money. Why disrupt ourselves?

John Marchica:

Karthik, is it about incentives? So, if I'm an employee benefit manager for Ford Motor Company, I'm the employee benefit manager, and I've been able to keep my costs... My cost increases from 1%-3% per year. By the simple fact that my employees, that it's expected that I'm a big company, and I provide them with health insurance, haven't I kind of met my end of the bargain, by giving them a benefit, by giving them healthcare, as well as internally or to our shareholders, ensuring their healthcare costs aren't blowing up?

Karthik Ganesh:

You absolutely have. The two questions I would ask you are one, outside of the access imperative to your employees, do you have a broader health and wellness imperative to your employees? Because, you may have driven that 1%-3%, and checked the box on your benefits by restricting access all over the place. Maybe they had a reduced formulary, maybe they had a reduced network, maybe they could only go to that one pharmacy on that one corner, and that's all they can go and get, that's the only place they can get their prescriptions from. As a result, if at one pharmacy in that one corner is a four mile drive away, maybe they're sitting out there saying, "I'm really sick. Maybe I'm just going to go and skip it today. I'm not going to make that. I'm not going to go and pick that up."

Or, maybe in that same example, I worked for the Ford Motor Company, let's say I'm an hourly employee. Let's say I'm actually a nonexempt employee. I'm challenged right now because, I think I saw a stat the other day, and I don't know what Ford pays their employees, but the minimum wage cannot pay rent in any state in this country, a person on a minimum wage. So, people are making fundamental pocketbook decisions about healthcare. "Do, I refill my prescription? Do I go see a doctor or do I buy groceries this week?"

So, what is the healthcare imperative for an employer? If the imperative is to check a box and say, "Yep, I did the right thing, I provided benefits, and let me move on," the retail model is beautiful, because it really is about, "Let me shrink access wherever possible, let me work with these guys, figure out how we can have no more than a 2% to 3% year over year increase, check the box. I'm providing benefits. Let me go and focus on something else."

John Marchica:

Well, I would say, and I was giving you an extreme example, I would say that most employers are a little bit more enlightened than that.

Karthik Ganesh:

You're right.

John Marchica:

They want productive employees. They want happy and productive employees. They want healthy employees. They don't want people taking unnecessary time off, or dealing with the kind of distractions that you were talking about. So, they have programs for diabetes, they have wellness programs. They have all different kinds of things, that they believe is not only good for their employees, but it's in the good corporate interest as well, to have that kind of enlightened attitude. It's not even really enlightened, it's in their self-interest. But, it doesn't get to the value point that you were making.

Karthik Ganesh:

It doesn't get to the value point, and you actually brought up a really good point as a part of that. If value was about fundamentally moving the needle, I would say, we've been sitting on these condition oriented programs, as a very viable check the box for 20 plus years, 25 plus years. It's been easy to do it that way because, for pharma companies, from a drug manufacturing standpoint, they're manufacturing drugs based on the dominant diagnosis. COVID just shattered that concept. We've known this for a while. Managed Medicaid and a bunch of other places, it doesn't work when you go condition oriented, because you're not really adding value. COVID just shattered that. You could have John sitting out there, you could have Joe sitting right next to you. Let's say you're a diabetic, so Joe's a diabetic. Maybe you've got a certain set of morbidities, maybe Joe's got a certain set of comorbidities similar to yours, or maybe not, because we don't know. So, both of you would check the box for diabetes management program.

But, let's say Joe's African-American. The Coronavirus likes Joe a whole lot more than it likes you, John. So, this notion of working off of condition oriented clinical programs, which has been tried for the last 25 plus years, and really hasn't been the cost curve, I would almost argue that, that isn't consistent value either. Value is when you continually take a step back, you're dispassionate about it, you evaluate what's working and what's not working. You're willing to disrupt yourself, because you're trying to get the right answer, the right value oriented answer at the end of it.

Karthik Ganesh:

I just got done reading Bob Iger's book, The Ride of A Lifetime, which is the Disney story. If you look at Disney Plus, Mulan's going to come out in Disney Plus in September, before it even comes into theaters. A fundamental step back by Disney to say, "Value is about convenience at this point in time, to the consumer. I'm willing to disrupt myself, even if I've always done it a certain way. I'm willing to disrupt myself, if it is the right answer." Condition oriented clinical programs have not been the right answer for a really long time. Every CFO who ever signed off on a disease management program, did that with significant heartburn.

I bet 90% of the CFOs in this country would sign up and say heartburn, because there is no way to prove a one is to one correlation between the DM Program, really moving the needle for that condition. Versus that, it's about taking a step back, looking at population risk, tailoring your clinical strategy to that population, understanding what the underlying morbidities are, and then actually putting clinical programs in place that move the needle, as it very specifically pertains to that population. We have the technology, we have the wherewithal. That is value.

We keep... This is where I struggle when I look at the industry at large right now. I've been doing this for 20 plus years. There's a lot of ways to define value, but when you look at it from my healthcare lens, which is what we're supposed to be in, it takes the variability out. It's about getting to a healthier person at the lowest price point, while making sure they feel well taken care of. Clinical, financial, service. That's where PBMs, that's where we are very unique compared to every PBM in this space. We are the only PBM that is completely value oriented. Our financial model is a pay for performance model, which if our client doesn't save money, we don't make money. It's as simple as that. We've got no automatic fees that show up, that we will just keep cashing an administrative fee, with or without the client getting any financial relief off of it.

Karthik Ganesh:

We're the only PBM in this market, that deploys a tailored clinical strategy, to that specific employer's population. We use the Johns Hopkins model as the underlying model, to analyze risk, both clinical and financial. We've surrounded that with a lot of our own business rules, in terms of clinical appropriateness. Every single client is a client of one. No one size fits all. They're in their own zip code, they've got their own set of morbidities, they've got their own constructs going in. We're doing... Behind the scenes, we've got the socioeconomic and the social determinants of health analysis going on, on every single client, so we can tailor a clinical strategy to that client.

Then when we look at service, we've put things like complex case management, et cetera in place, so that the folks who need the virtual hug are getting it, even before they feel the need to pick up the phone and make a call. We're actually making outbound calls to every single person we deem as being complex. Complexity could be high risk, I'm on a lot of drugs, or I'm just a frequent flyer into the HR person's office, because I've got a lot of questions. Whatever the case might be, we're giving them a virtual hug with a 24 by 7 model.

John Marchica:

With EmpiRx, aren't you going back to the size question again? Aren't you still at a disadvantage? You still have to pay for drugs, you still have to have some manufacturer contracts. I'm assuming that you can't buy at the same rate as an Express Scripts. So, how do you get around that problem, that retail problem, and the size issue, in terms of the purchasing?

Karthik Ganesh:

So, there's two pieces here. Let's take the purchasing aspect, and then let's get back to healthcare in the second part of it. The purchasing aspect to it John is, we spreadsheet extremely well, compared to anyone out there. We spreadsheet extremely well because, in that 100 and 130 bucks example that I gave you, when we buy something... We have no direct manufacturer relationships, one. But, when we get something for 100 bucks, we're spreadsheeting it for 100 bucks. Because, in most cases, we're getting what we're getting. For us to be competitive on a spreadsheet, we have to pretty much give up what we get. That's one part to it.

So, we have not seen, by virtue of going up against these really large organizations, we haven't seen an impact per se. I mean, yes. There's places where we get impacted, but those are few and far between. On a spreadsheet, what they're willing to put on a spreadsheet, compared to what we are willing to put on a spreadsheet are very comparable. Now, you take the other part to it, which is really, "Well, how do

we really drive value, if we're not able to drive value with the traditional levers of, I'm going to give you a deeper discount?"

Where we drive value is by basically taking this approach of, putting clinical guarantees in place. Our clinical guarantees aren't a disease management kind of guarantee where, "Well, I've got two claims that I can show you, and then I'm going to extrapolate based on industry studies, and tell you, "Well, approximately I should have saved you X." Now, that's not how it works. We are the only PBM that will put on paper, will give a client or an employer, a claim by claim audit of what was prescribed, how we worked directly with the physician in a consultative conversation, convinced the physician, who controls the pen, convince the physician to switch the therapy to Y, from X to Y, and how don't firm and said, "We're not going to count that as a win for 90 days, in the event the patient went back to the original therapy, and then we count that as a win."

We are going at the financial saving paradigm, the cost paradigm that has bogged down pharmacy benefits forever. We're going at it purely from a clinical appropriateness lens. We're basically saying, if you were... Our model is proving this out. We're not a young company. We're a five and a half year old company. So, we've had clients who've now been with us for five and a half years. We're proving this out that, by doing the right thing clinically, you can drive down spend.

Karthik Ganesh:

The bulk of our books sits on flat PMPMs year in, year out. There is enough clinical ways being accumulated, that they need someone like us to come and help suffocate those costs. Every other PBM, that's the aligned model. Because in our model, if we are able to drive down volume to the most cost effective therapies, it's a win. For every other PBM that's volume oriented, which is everybody else, the more the volume goes up, the more they win. Just a simple case in point, you look at the earnings calls, last week, a bunch of folks came out of their earnings calls. A number of folks, as they spoke about their pharmacy business, clearly said, "As a result of our clinical programs, we're going to have... Our members are going to be utilizing more drugs, more profitability."

Since when did more drugs equate to better health outcomes or reduced cost for the employer? Come on. We've been doing this for a while. How's that even intuitive?

John Marchica:

Right, right, right. I'm still wondering, and I'm not asking for the secret sauce here, but if you're not basing your revenue stream, based on that spread, based on the resale model, how do you charge for your services? What is your model? Can you talk about that?

Karthik Ganesh:

Sure. It's quite simple, right? You take the approach of we make money... We're going at risk essentially, right? It is a downside risk bearing model, because we've got no admin fees. Unless we hit those savings guarantees, we're at risk. Because, what we basically tell the client is, we actually do... When a client, a prospect comes in, John, we will look at their data, and we will basically put a clinical guarantee on the table, based on the inefficiencies we see in their utilization. We tell the client, "If we don't hit that guarantee, we will pay it out dollar for dollar. And Oh, by the way, we're not charging you an admin fee along the way."

After we hit that guarantee, this is where the alignment comes in. I don't know if you remember the Schwab commercial from a couple of years ago, where you had this dad and son sitting across the table from each other, and the dad says, "Well son, you're earning now. Congratulations." He says, "Have you thought about investing?" The son says, "Thank you, and yes, I have been doing some research." The dad says, "Well, I've got a broker for you." The son says, "Well, if he doesn't hit your financial goals, does he pay your money? Do you get your money back?"

John Marchica:

Yeah.

Karthik Ganesh:

The dad says, "Well, that's not how the world works." The son says, "It's a new world dad." Remember that commercial?

John Marchica:

I do. I very much do.

Karthik Ganesh:

That's the model. Alignment requires that, if the client commitment is not met, if they are not saving what was guaranteed to them, we should not make any money. Now, after we deliver on their guarantees, every dollar saved over and above that, we work with them to monetize it. It could be a variety of different ways. It could be an admin over and above that guaranteed dollar amount, it could be a care coordination fee, whatever the case might be. But, we would work with that client, to figure out the right way to monetize over performance. Here's what the client still gets. Even with that over performance clinically, they're still getting deeper PMPMs as a result of it, because their spend is still going down. Because, what we're monetizing is never going to be equivalent to how much they would have spent on those medications.

So again, you're talking about alignment. Again, when you think about, you break all of it down, value is about alignment. You are the buyer, I am the seller of services. If I can tailor my entire financial proposition based on your satisfaction, we are aligned. We have a value oriented relationship at that point in time.

John Marchica:

True.

Karthik Ganesh:

Alignment can only come where you're willing to put your own capital on the line and say, "If I don't get you satisfied, I will pay the difference to make sure you're satisfied."

John Marchica:

Well, it's an intriguing model. It's been a pleasure speaking with you, and learning about this concept, as well as, I always enjoy talking about value. It's something that seems to come up in every other podcast, because people have different notions about what value is. I wanted to wrap up on a different note.

Karthik Ganesh:

Sure.

John Marchica:

A couple of years ago, you wrote The Happiness Model. Is that right?

Karthik Ganesh:

Yeah.

John Marchica:

I had written a book called The Accountable Organization when I was in my 30s, and I had just undergone a rebranding process, and I thought I had something to say about business. So, I went through the process myself. I know for you, there are very different reasons, but I'm curious, my colleague says the book is terrific. Tell me a little bit about that process, and why you decided to write the book.

Karthik Ganesh:

2012, I lost my daughter to cancer. She died of an inoperable brain tumor. It's the same thing that Neil Armstrong's daughter died from, in the early '60s. It's been the Holy grail of tumors and cancers for 40 plus years. It hits kids, and it's got a 0% survival rate on it. So, 2012, she passed away from that. As you can imagine, I just had a lot of questions. Why are we here? Just fundamentally questioned my very being. I embarked on leveraging some really ancient philosophies from the East. I embarked on what I would call, I like to call it more of my own inward journey. It really was for the next three or four years for me, it really was an act or a journey of building significant resilience personally, to realize that everything around us is impermanent. Everything.

The only thing that is truly permanent is within us. You can give it a name. You could call it fate, you could call it God, you could say, whatever that anchor is, resides within us. With the entire answer, if all your answers to inner peace, resilience, and as a result, happiness lies within you, why would you go looking for it elsewhere?

So, the book was really a culmination of, not a culmination, but it really was at a point in my own journey, where I felt I had something to share with people who were going through their own personal challenges. The idea was to make it very accessible, to make it very intuitive, and to really make it, it's very difficult, but to really make it very doable, if a person were to deliberately practice out of this, the Malcolm Gladwell construct, of 10,000 hours of deliberate practice, which you're deliberately practicing something, you build enough muscle memory.

If every single thing that hits you, irrespective of whether you want to brand it as good or bad, if you say, "I'm not going to give it an attribute, I'm just going to accept it, and I'm going to say thank you for it," the attitude of gratitude, that is based on deliberate practice. Then, doing whatever you do to the best possible extent, so you have absolutely no what ifs in life. We're blessed to be able to have this conversation, right?

John Marchica:

Yeah.

Karthik Ganesh:

So, to be able to live each day and give it your best shot, and when things don't work out the way they're supposed to, accept life for what it is, and then pick up the next day, and take another step forward. That's The Happiness Model.

John Marchica:

Wow. Well, I can't wait to read it. It sounds like a very challenging, but uplifting book, just based on what you're saying. So, I encourage folks out there to... We're not here to hawk at books. That's not the point. We're here to talk about PBMs, and value, and everything else. But I have an [inaudible 00:41:30] of one, a colleague who says, as I said earlier, he says it's terrific, and I'm looking forward to reading it as well.

Karthik Ganesh:

Thank you, John.

John Marchica:

Karthik, thank you very much for today. I appreciate you spending so much time with me.

Karthik Ganesh:

Thank you.

John Marchica:

I hope we stay in touch really. Best of luck with EmpiRx.

Karthik Ganesh:

Likewise. Take care. Thank you. Bye-bye.

John Marchica:

Take care.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Health Care Rounds is produced by me, Kim Asciutto, and is engineered by Andrew Rojek. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence, and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems, and the global shift for value-based care. Find us at Darwinresearch.com. See you next round.

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