Announcer (00:03):
Welcome to Conversations on Health Care. This week we welcome renowned entrepreneur and popular "Shark Tank" host Mark Cuban, who is seeking to disrupt the prescription drug market with his new venture Cost Plus Drugs. Now, here are your hosts, Mark Masselli and Margaret Flinter.

Mark Masselli (00:19):
Our guest today is a well-known entrepreneur, responsible for multiple startups in digital media, software development and blockchain. The billionaire businessman is a popular co-host on the hit series Shark Tank, and is a principal owner of the Dallas Mavericks basketball team.

Margaret Flinter (00:35):
He has increasingly lent his support on Shark Tank to startups that seek to address inequities in American healthcare. And recently he launched his own enterprise, the Mark Cuban Cost Plus Drug company, a public benefit company, an online direct-to-consumer pharmacy that aim is to take on the high cost of prescription drugs.

Mark Masselli (00:55):
Well, Mark Cuban, welcome to Conversations on Healthcare.

Mark Cuban (00:58):
Thanks for having me. I'm excited to be here.

Mark Masselli (01:00):
Yeah. And Mark, prescription drugs now are a major factor in the almost $4 trillion a year that gets spent in healthcare in this country, and one out of five Americans can't afford at least one of their prescription medication. And you say there are far too many middlemen in the prescription drug pipeline, which significantly adds to the cost, and you're promising to radically be transparent about the cost. How does that differ from the status quo?

Mark Cuban (01:30):
I mean, significantly. I mean, there's very much a vertically integrated environment right now where health insurance companies own PBMs and own retail pharmacies and are expanding into other areas of healthcare, and they keep on creating these fortresses where they control the left pocket and the right pocket. And by having so much control, they're able to create an environment where pricing is opaque. It's confusing, and they have a lot of control. I mean, and on top of that, because they're able to contract with insurers and major corporations and consultants, they're able to play these games where they'll say, "Okay, if you want access to all these lives, then you have to do business manufacturers the way we want to do business." And that is unfortunate and creates a lot of pricing distortion for patients.

Margaret Flinter (02:28):
Well, Mark, our organization delivers care to a large vulnerable population, and I think we do a pretty good job of helping patients access prescriptions at prices they can afford through various programs, but it does take an enormous and concerted effort. Medicare itself had been blocked from negotiating drug prices, but that's now changed under the President's Inflation Reduction Act. How do you think this new development is going to these issues that you've described in the marketplace?

Mark Cuban (03:58):
I think it'll improve things, obviously, for the 10 drugs and then moving up to more drugs over a period of time. I think it's great for people on insulin who are on Medicare. It doesn't do much of anything for everybody else. That's just the reality. And so where there are out-of-pocket limits, the $2,000 will make a big difference as well. But until you get to that $2,000 limit, there's going to be challenges for Medicare patients. And on top of that, you have Medicare Advantage, which is completely distorted, completely confusing and completely rewarding, not to the patients, but to the owner of the Medicare Advantage Company. And so it's just there's still a lot of messiness and that's one of the things we're hoping to attack.

Margaret Flinter (03:45):
Great. Well, we look forward to hearing more about that. Thanks so much.

Mark Masselli (03:49):
Mark, you just a few months into your new venture and you've just inked your first health plan deal, Capital Blue Cross in Pennsylvania to provide low cost prescriptions to their members. This space is highly competitive, so how did it come about and how will it work for the consumers?

Mark Cuban (04:08):
Well, for the consumers initially, and congratulations to the PBC in Harrisburg and Allentown Capital has just been a phenomenal partner. The way it starts is they'll refer their patients to us and then using a form, they'll reimburse them. We're updating our software so that shortly it'll all be automated, so you'll just buy through Cost Plus Drugs and everything from there in terms of applying to your deductibles and we're applying to the right programs. All those things will be handled on an automated basis. And with that, not only was capital our first, but we're also partnering with Prime Therapeutics, which allows us to talk to a lot of other blues and we're hoping that leads to many other insurers to work with us. And obviously we're also talking to many, many, many independents because other than the big three, it's very difficult to control their own pricing and their paying premiums, and they're kind of caught in the vortex of dealing with the PBMs, and so we're trying to yank them out of there and the response has been great.

Margaret Flinter (05:15):
Well, Mark, it certainly seems that this approach could save billions of dollars each year for consumers, but we point out, as I think our audience knows, it still only targets about 20% of the medication market, if you will, the generics. And non-generic drugs make up about 80% of total drug costs in America today. And these cost is people who are on them know can be just astronomical and often life-saving and absolutely essential. What do you think the chances are that your model could eventually expand in ways to the non-generic market, which is so protected, of course, by trademarks and regulations?

Mark Cuban (05:58):
Absolutely, a hundred percent. We'll make our first announcement tomorrow for our first branded partnership, which we're really excited about. We're in process of negotiation with many others. They see the same problem. One of the challenges that manufacturers of branded drugs face is that they've been villainized. Everybody perceived that using insulin as an example, everybody thinks that they're responsible for the increasing cost to patients for insulin. When we know people in the industry know that's just not the case. That the price that manufacturers sell insulin for has actually declined. If you look at their revenues for insulin, they've declined. And so part of why they're excited to work with Cost

Plus Drugs is the transparency. Finally, now patients and others in the industry will be able to see exactly what we pay and what we charge for insulin. Or for the drugs we're adding, not adding insulin, but the drugs we're adding, I misspoke there. We like to add insulin and we're having conversations, but we're not there yet.

Mark Masselli (07:02):
Mark, you said earlier that the pharmacy benefit managers play a big role in elevated drug costs, but we often hear that drug research and development is also baked to the consumer, and some say these low cost approaches will dampen the pace of new drug development. The Congressional budget office has indicated this as an overstatement. What do you say?

Mark Cuban (07:24):
Well, you have to ask who's saying that It's not really the manufacturers that are saying it. It's the lobbyists that are saying that. Manufacturers know that they're not going to bat a hundred percent on their drugs. And so for certain there's a price associated with R&D, or if you're not doing the R&D yourself, licensing or purchasing and then getting all the approvals and all the marketing, there's a price associated with that. Some of them will fail at the trial level, some of them will fail in the market, and so you've got to build all that into how they price. But what happens is because the manufacturers for the most part, not always, but for the most part, don't actually have control of their own retail or net price, that's where a lot of distortions come in.

(08:08):
And so again, if this was just an open market and it was 1955 and the pharmacy bought from the drug manufacturer, and you sold it to the patient, and this was truly free market, then you would see that which drugs made it, which drugs failed, approximately how much they spent, and you would have an understanding of a fair price to charge. Now, that's one element of it. Part two, and particularly as it applies to specialty drugs, which are the ones that are very expensive and have the high levels of sticker shock, there's a different equation for determining whether or not a price is fair. If there is a medication that adds 10 years to your life and eliminates having to go to the hospital, is $5 million too much?

(08:54):
If the cost of going through care and being in the hospital to take care of that disease before the medication was in place was greater than $5 million, well, somebody's saving money. The problem in all of this is that it's not the insurance companies that are typically saving the money, and that creates the push-pull that is creating problems as we talk about specialty medications. And that creates a lot of challenges, depending on which side of the ball you're on for people going to the specialty drug programs because the insurance companies don't want to pay for them. They're trying to force those patients to specialty programs, which so effectively they're trying to get the manufacturers to provide these high-end expensive medications for nothing so that the insurers don't have to pay what they're obligated to pay.

(09:47):
So all that said is I don't think that there's a world for specialty drugs where the current healthcare insurers are able to model what their out-of-pocket expenses are going to be for specialty drugs because it's almost impossible to project which ones are coming and which ones will succeed. It's almost impossible to project the actual impact even though, what do they call it? Incel or Insight, I forget the name of the organization that tries to do a cost benefit analysis. They try, but you've got, again, you've

got this challenge that what the insurers want, the people who we're looking to pay for it and what the patient wants and what the manufacturer wants are not aligned at all.

(10:35):
And so I happen to think that over the next five years, it's going to be very politically expedient for some administration or some politicians to say, you know what? We need a public-private partnership that excludes insurance companies so that these high-end specialty drugs, even if they're 500,000, a million, 5 million, $20 million, whatever it may be, are evaluated to make sure that pricing is fair. Two, by having a public-private partnership, one of the challenges for those specialty drug manufacturers is percentage of valid patients receiving the medication and them getting paid for it.

(11:16):
So if there is a medication, let's just say for easy math, that has a million dollar price tag and has a potential annual patient base of a thousand people, right? Right now, they're not going to be able to get approvals for all thousand of those potential patients. And the reality is they're struggling to get any percentage of those patients paid, and it is more high-end people like me who are able to afford those things. And so through a public-private partnership in some independent research, you'll be able to say to them, "Look, you can't charge a million dollars for these thousand patients, but we'll guarantee you that all thousand patients will be able to pay for it and we will buy your drug from you for all thousand, but you're only going to charge 500,000 so that you net out at 500 million in revenue as opposed to your hope for $1 billion in revenue, a million times a thousand."

(12:14):
"And let's work that way so that it's fair to you as a business, you have incentives to keep on releasing, buying or developing these specialty drugs. It's fair to the patients, all of them who have valid prescriptions from their doctors, from the provider are able to get it, which is the most important part." And we take the organizations that are the inhibitors, the private insurers who don't want to pay for it and don't see the financial benefit from it because across all the insurance companies, if they paid out a billion dollars, their math probably says, in their models that they're not going to get a billion dollars in savings. So they do all they can to prevent paying for it.

(13:00):
And so we need to be honest and straightforward and have some transparency, and if the manufacturers of the specialty drugs are willing to do that and we're able to everybody get on the same page, then I think we save a lot of lives and improve the healthcare system. If they don't, and we have this continued push-pull as always happens where the insurers do their best to deny claims or pre-authorizations, then we have problems. That was a longer answer than you wanted, wasn't it?

Mark Masselli (13:27):
No, it was good.

Margaret Flinter (13:29):
It was a compelling answer and I think we have another interview, another show perhaps in our future to really tease this out more. I can tell you it's pretty awful on the ground where the patients live as this issue is dealt with on a regular basis. But let me pivot just a bit, Mark. The Covid pandemic amplified so many shortcomings, inadequacies in our healthcare system and supply chain was right at the top. We were caught short on so many things we needed to protect our healthcare workers and the public. But

you are going to actually be scaling up your own drug manufacturing factories for Cost Plus Drugs. So tell us about that and what other supply chain issues do you see as ripe for disruption?

Mark Cuban (14:18):
So effectively, there are a lot of drugs that go into shortages, particularly generic drugs where there's just not enough of a market for manufacturers to continuously produce them. And so what ends up happening is they just jack up the price, we've seen that happen multiple times. Or you get in a situation where you have sterile water, like now, which is hard to come by, and even though it's not hard to make, there's just no manufacturers to do it. So with Cost Plus Drugs we created, we're building, we're finishing out actually, a manufacturing plant in Dallas, Texas that is robotically driven so that it only takes us four hours to turn our manufacturing from one injectable to the next.

(15:01):
And so starting with things like sterile water, excuse me, we'll talk to all the hospitals and all the providers that need it. We'll come up with a fair price that covers our cost because as a manufacturer, we can't just do a straight cost plus 15%. Our costs are much higher as a manufacturer, but we'll be compelling transparent price and we'll make it available for whatever injectables are in short supply. And then when we fill that need, it takes four hours for us to cycle to the next drug. We'll do the next one, then four hours, we'll do the next one, and then the next one and so on and so forth. And if it works out well, we have plenty of room to expand to add more and more for oral medications, you name it, we'll be able to expand to it presuming that everything goes the way we expect it to.

Mark Masselli (15:50):
Mark, one of the health companies you develop is Unite Genomics, which you say is focused in on advancing medicine through large-scale analysis of genomic and health data, especially for rare disease. How does Unite Genomics dovetail off similar efforts like NIH, All of Us Research Project or the patients like me, and perhaps more broadly, how will genomics and personalized medicine shift the future drug development landscape?

Mark Cuban (16:18):
Well, the honest answer to Mark is, I don't know. I've been so focused on Cost Plus the last few years. The guys at Genomics know their stuff and they run their show really, really well. But just generically, generally, our bodies are one big math equation. We don't know how many variables are in that equation, and we don't know what all the variables are, but every single day with advancements and chips and GPUs and just about every other core component of artificial intelligence, we're learning more and more and more about our bodies and we're aggregating more and more information from all the experiments and all the tests and all the trials and all the databases that we're able to have access to. And when you start mixing those together over time, you truly do get to a point where you have more and more personalized medicine, and that's part of their goal, to be part of that revolution. Again, I wish I had just looked up, I just haven't had the time just to keep up with them. I'm just trying to keep up with what's going on in Cost Plus.

Margaret Flinter (17:22):
Well, you have a lot to keep track of. And this question may be in the same category, but maybe not. You're certainly well familiar with startups and the challenges, and I assume both success and failure, but in healthcare of course, there's so much at stake with failure in any element of healthcare. What have your startup experiences in other areas taught you about how you're going to go about this

process with your new company doing it without harm? Share with us what you've learned about the process.

Mark Cuban (17:54):
I mean, data matters, care matters, being transparent matters because look, there's no mistake-free anything anywhere, whether it's healthcare or selling nachos at a Mavs game, there's always going to be mistakes. The challenge for patients as it applies to healthcare is we're not as transparent as we need to be. And when you're not transparent, then people don't trust it. And the reality is the number one product that Cost Plus Drugs sells is trust. If you think about the process of getting a prescription these days, typically you go to the doctor and if it's the first time the doctor says, "Sorry, you need to get this," whatever it is. "What's your pharmacy?" And then you just get the prescription sent to your pharmacy, and then when you get to the pharmacy, the pharmacy doesn't know what they're going to charge you until they ring it up and you don't know what you're going to be charged.

(18:46):
You're hoping all your insurance covers it and you don't know. Typically, you may or may not know your copay, and then you don't know what all your options are. So I think true missing piece as it relates to your question, Margaret, is transparency. We have to get to the point of trust. We trust our doctors, but look at just hospitals. Everybody wants to trust hospitals. Everybody pretty much does trust the doctors in those hospitals, but when it comes to organizational or administrative, they can't even get them to do what's legally required of them with transparent pricing on their websites. There's people paying the ridiculously low $100 a day or whatever it is, and who are ignoring the obligation to really provide the numbers in a way that's understandable.

(19:36):
I mean, I had a CT colonoscopy and I had a CT just because I do them every couple of years and I just pay cash price. I don't even go through my insurance simply because, A, we self-insure and B, I kind of like going through all the hospital spreadsheets to see what the pricing is, but I'm certainly the exception and not the rule. Without transparency, there's no trust. And when you have organizations creating reasons for, and hospitals providers creating reasons for them not to be trusted, then that's where things go south and they become politicized. There's just so many ways that we can improve it, but everybody's fighting for their next dollar instead of fighting for their next patient. Not everybody, that's not fair, but from the administrative side.

(20:24):
I mean, look, in healthcare, what is it? 21% of the total cost of healthcare in this country is administrative, and there's so many easy things that you can do. You could standardize contracts, right? Network contract for every hospital, use a standardized contract that is reviewed, whether it's annually or bi-annually, whatever it is. Then just the numbers change and cut the cost and all the retail or all the detailed research that has to be done every time someone walks in the door with a different network or a different insurance plan, and it has to go up the flagpole six feet deep, and then the provider does everything possible to complicate it. My mom died of cancer this past February.

Mark Masselli (21:05):
Yeah, sorry to hear that.

Mark Cuban (21:07):
Thank you. And she went in to talk to the doctors and the doctor says she needed a PET scan. "Okay, let's get her a PET scan while she's here." No, you can't get a PET scan while you're in the hospital. You have to leave the hospital and come back more than three days later so they get paid the most. My mom was like, "No, that's ridiculous." Do you know what it costs her and it costs me and it costs my family? Because this is the ridiculousness that patients have to face. And it's not like the hospitals don't know what they're doing. When they up code, when they recode, when they dual code, we saw all the article in the New York Times for Medicare Advantage.

Mark Masselli (21:53):
Yeah.

Margaret Flinter (21:53):
Right.

Mark Masselli (21:53):
Medicare Advantage.

Mark Cuban (21:55):
That's insane. Put me in charge. I'll make a criminal if you do that, period, end a story. Because once you create distrust in the healthcare system, you get what we had with Covid where people don't trust, they don't believe anybody and what they're saying. We don't know what something's going to cost before we go to a doctor, and there's some trying to create transparency, but the games that people play at providers. A friend of mine runs the hospital. It is weird how it all played out. Guys I grew up with run, there's several hospitals, and so I keep in touch with them and they had built this building and they were asking me what I thought was the best approach to getting more people to the building.

(22:36):
And I was like, "There's only one answer. Sell the MF building. Take that and reduce the rates and make it more accessible. You don't need a fancy building. You need the equipment you need, you need the doctors, you need. You don't need fancy buildings." Yet that's what you see on every hospital campus, fancy buildings. And I worked with a group and I asked a very simple question, and if this is too far afield, just tell me.

Mark Masselli (23:02):
No.

Margaret Flinter (23:02):
No. Go ahead.

Mark Cuban (23:04):
I'm like, "Toronto Canada, right? Their real estate is more expensive than Manhattan. Their doctors get paid the same, their nurses get paid the same as hospitals in Manhattan. Why are all their procedures less than Medicare?" And it's really simple when you start looking at it. One, they're mostly non-private rooms. I actually had kidney stones in Toronto one time. They put me just a little curtain around me, which I was fine with. They took care of me, but it was not a private room and I was great. In our hospitals, once you get past the municipal hospitals, it's all private rooms. And in Canada, they pay for all

the doctor's liability insurance. In Canada, the hospitals are sure they'll get paid for all the patients that come through the door. These are little things that we complicate here in the United States through DISH and no liability compensation, and everybody's trying to be fancy when you do that. And there's not a lot of transparency. People aren't going to trust and it's going to be more expensive and people are going to go without healthcare, and that's just insane.

Mark Masselli (24:17):
Mark, on one side, you're battling on the trust and transparency side, and you're coming up against on the other side, some legacy players in the big pharma world with a lot of skin in the game. CVS Caremark made about 150 billion in prescription drug space in 2021 alone. Ann Walmart and Costco have well established supply chains and market share. You've got Amazon turning to direct consumer drug purchasing as well, use a base basketball analogy. How do you out shoot the legacy teams? What's your edge in this really crowded field and when so much profit is hanging in the balance?

Mark Cuban (24:56):
Well, there's this old saying I use all the time, when you run with the elephants, there's the quick and the dead. And we're really, really quick. We're agile, we're evolving all the time. We started off just mail order. Hopefully within the next 60 to 90 days we'll have a discount cards. So you'll be able to pick up at a local pharmacy at our pricing because they'll buy from us and agree to our pricing. And on top of that, rather than some of the other discount cards do, which is charge the pharmacies for the traffic, we'll actually pay the pharmacies for fulfillment. Or I should say, we'll let them charge, which I think the pharmacies are going to love. So that's one way to do it. You look where the greed is. Jeff Bezos family said, "Your margin is my opportunity." And that's exactly what's going on here.

(25:43):
Cost Plus Drugs already has more than a million accounts. Nine months in more than a million accounts, and we're growing rapidly. By the time we finish this, we might be at a 1.1 million. And so if we get enough of a base, people are going to want to keep on working with us no matter what the other ones do. Maybe they come along and match our pricing, that's okay by me. Maybe they come along and do the same thing and just copy us, that's okay by me. If the net result is okay, Cost Plus isn't as big as it might've otherwise been, but everybody's playing Cost Plus 15%, hello, problem solved. And so of course that's easier for me to say than for all that to happen.

(26:27):
But at the same time, when you're as big and public, excuse me, as the big three and you're as vertically integrated, and there's so much right pocket, left pocket, they create or buy this company where they send some margin there and then that company buys from another one of their subsidiaries and they send some margin there. It's awful, awful hard for them to be cost competitive. There's just too many layers and too much hierarchy for that to work. They might be able to absorb some losses to try to combat us, but I think we'll be okay. And I think, again, our number one product is not a medication. Our number one product is trust. And if those other outlets were truly trusted, we wouldn't have any customers.

Mark Masselli (27:11):
Mark, I heard you say in the last answer to Margaret's question that if someone put you in charge, is this an announcement of any candidacy that we can report on?

Mark Cuban (27:20):
No, no, no. Absolutely not. No. My family would just own me. Absolutely not. But some of these providers need skin in the game in terms of their obligations to living up to the law. A hundred dollars fine per day isn't going to make anybody change their actions. There's just so many fraud and pay a fine. That's not going to make anybody change their actions. There's just so much money involved, and that money keeps on getting bigger and the fines become a smaller, smaller percentage. The minute somebody that works anywhere in that food chain in a major corporation is that fear of going to jail, it all changes. It all changes.

Margaret Flinter (28:05):
Well, Mark, I know you are completely focused on Cost Plus Drugs right now, but I've read you're also pretty interested in the potential for new technologies like wearables and AI to improve health in that little bit of time. You might have to think about those things right now. What's exciting you right now about the growing potential of AI and health sensors, digital health, what else out there captures your imagination and your investors like?

Mark Cuban (28:34):
All the above. I mean, I'm a big believer that there's two types of companies in this country, those who are great at AI and everybody else. If you look at the top 10 market share companies that are public, they're great at AI, no exceptions, the Apples, the Googles, etc. And they're also great at acquiring data. Now, we can argue about the privacy issues, but I think the ability to use AI for personal healthcare is only going to improve. I got criticized for this six, seven years ago when I talked about it online, but I get my blood tested every four to six months because I want my baseline to be my baseline, not Mark and I being base lined against the exact same numbers for what a white male in our age group and Mark's luck, younger and handsomer than I am, but in our age group is supposed to be benchmarked at.

(29:27):
That's just crazy. And so I started getting my own blood work. I go to Quest Diagnostics or wherever, capitalize that, connect it with my iWatch and capture that data. And the point being that the more data we have available to us, I think the smarter decisions we can make as patients. Now, doctors will tell you that sometimes too much data is a bad thing because a lot of patients don't know what to do with it, and they get caught up in a vortex or a rabbit hole trying to figure out their own healthcare. But then again, that goes back to trust. If we're able to trust our providers, if we're able to trust our doctors and we don't rush our doctors and we give them a chance to explain what's going on to the patients and how this data actually impacts their lives and how it is or is possibly not useful, then we start getting better outcomes.

(30:18):
And I think AI has a real role to play. And those are the things I look at. I invested in a company, Genes Tesis, golly, seven years ago I think. What I didn't know when I invested in they're out of Cincinnati, is every one of the organs in our body emit an electrical signal. I had no idea. And there's scanners that capture that electrical signal, and the first one they work with is the heart. So they capture the electrical signal that comes out of the heart. They save it as an audio file, believe it or not, and then they run it through machine learning AI. And based off of tens of thousands of examples, they're able to correlate what issues the patient might be having with their heart. Because anybody our age knows, again, Mark, you guys are a lot younger than me, that you feel something in your chest, you immediately get nervous.

(31:08):
So many people go to the hospital and there's no quick way to resolve what that is. So you might get checked in, you might get sent home. It's really, really difficult. But using AI and Genes Tesis, they're going through their trials now. The hope is you get scanned, you run it through the AI, and it tells you with some level of accuracy the most likely thing that's going on with your heart, right? And is it AFib, is it whatever? And so things like that to me have huge upside, things that make us smarter, make us more efficient, allow us to do it for less. Those are all things that I think AI will drive and that I get excited about.

Mark Masselli (31:51):
We've been speaking with entrepreneur and Shark Tank host, Mark Cuban, who has launched an online entity, Cost Plus Drugs, seeking to shake up the prescription drug market with low-cost generic prescription drugs. You can follow our show and learn more about all of our guests at chcradio.com. Thank you to our audience for joining us today. And Mark, thank you so much for joining us and we'll continue to follow your innovations.

Mark Cuban (32:15):
Thanks guys for having me on. It was a great conversation. I really enjoyed it.

Mark Masselli (32:18):
All right, great.

Margaret Flinter (32:19):
Thanks so much.

Mark Masselli (32:19):
Take care.

Mark Cuban (32:19):
Thanks guys.

Margaret Flinter (32:21):