Redefining the PBM industry, A Conversation with AJ Loiacono, CEO at Capital Rx

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AJ Loiacono
CEO and Co-founder
Capital Rx

Frederic Laurier
Managing Director, Digital Health
ALANTRA

Pierre-Alain Rikkers
Managing Director, FinTech
ALANTRA

Episode Highlights

- AJ joins Frederic and Pierre to discuss the lack of transparency and complexity in drug pricing and the oligopolistic PBM industry structure, perpetuating a convoluted reimbursement system
- He argues that PBMs exploit the system's opacity for profit through "casino economics," with practices like spread pricing and clawbacks that financially penalize pharmacies, creating inefficiencies and inequities
- The traditional role of PBMs is for the administration of eligibility checks and formulary decisions, and relies on an outdated infrastructure. The healthcare payment sector lags significantly in transaction processing and would also benefit from a system overhaul
- The separation between pharmacy claims and medical procedure claims, as a result of distinct coding and transaction standards evolving independently, initially stemmed from the lower cost and complexity associated with pharmacy claims in earlier decades
- As costs and significance of pharmacy services grew, the lack of integration between pharmacy and medical procedure claim systems has led to inefficiencies and safety issues, such as repeated approval processes for patients and untracked drug-to-drug interactions
- AJ advocates for a unified claim processing system that treats both types of claim uniformly to improve service, efficiency and safety

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Episode Transcript

Frederic Laurier (00:06):
Welcome, all, to another episode of Crossroads by Alantra. We have the pleasure of hosting AJ Loiacono, CEO of Capital Rx, a provider of the backend infrastructure required for the processing of pharmacy claims in the US. I will be joined in today's podcast by our very own FinTech expert, Pierre Rikkers.

(00:23):
AJ, Pierre, welcome to our podcast. AJ, let's start with a quick bio on you first. You've been in the pharma supply chain management industry for over 20 years now. Initially, you were in the consulting side, if I'm not mistaken. Then you took turns initially as the CEO of Truveris and now, of course, of Capital Rx. Both are providers of software solutions to the PBM industry. Can you tell us how you first broke into the industry?

AJ Loiacono (00:49):
By accident. I think, most people, at least I never had visibility exactly what I wanted to do when I grow up. Very humble roots. I started in pharmaceutical manufacturing on the plant side. I used to help convert old supply chain systems, MRP to MRP2, to ERP platforms like Oracle and SAP. I did that for almost eight years of my life. Hard to believe. Time flies. But I had a first-grade education in supply chain logistics, drug pricing and software implementations that still works for me to this day, to draw upon those experiences.

(01:24):
But then I moved over to the opposite end of the supply chain, working with insurance, payers, employer groups, PBMs. I didn't even know what a PBM was, even though I was technically in pharmaceutical manufacturing, pharma, the broader umbrella, but I didn't know what a PBM was. This pharmacy benefit manager that administrates benefits on behalf of typically self-insured payers or forms the backend infrastructure to process prescription claims for carriers and regional health plans.

(01:59):
And it was during that time I discovered all the flaws in the US healthcare system. It was a bit outrageous to me. I had never seen an industry with the amount of opacity and complexity, as well as the self-interest driving these decisions solely for benefit for the people that are administrating, not the patient and plan. I often joke, care is in the name of healthcare, but oftentimes, executives and companies ignore that part of the responsibility.

Frederic Laurier (02:32):
What do you feel are the main reasons why we have the convoluted reimbursement system we have now, whereby three major firms, Caremark, Express Scripts, and Optum Rx, not to name them, control roughly 80% of the market?

AJ Loiacono (02:45):
Yeah, I mean, I always say if you have the perfect market, and what am I describing with pharmacy benefit administration is that you have an inelastic demand curve. So, it doesn't matter if we're in a recession or boom times, patient utilization holds rock steady. It does NOT budge. It's like no other industry. It's not energy services. It's not real estate. You can always count on it.

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(03:08):
The second thing is list price goes up every year. So, the perceived price of drugs, and I use the word perceived because we're going to talk about something in a bit called net cost, which is more of a reality, but the list price inflates on every drug every year, and this is problematic. When you have a situation where list price inflates, inelastic demand curve, so you have this compounding of inflation, you have the perfect market. So, you don't innovate. As someone who administrates benefits, you consolidate. You buy more and more and more of it, which is what we saw in the 21st century, which gave birth to the companies that you just mentioned.

(03:50):
And so, when you have this consolidation ... You asked me the question of what caused this overly complex system? One of the examples I give is in my industry when you're dealing with benefits, you have all of these odd terms to describe drugs. Like this is a single source generic, this is a multi-source brand, this is a brand, this is a generic, this is a specialty drug, this is limited supply, this is DAW handling. And all of these combinations can move things from different lists and reclassify the drug to different pricing schedules.

(04:23):
And if you come from manufacturing, we're very simplistic people, we have two forms of classification. It's binary. It's you're either patent protected or not patent protected, and everything has a drug code and that tells you exactly what you're dealing with, and that has a unit cost. Very specific economics and pricing. But when you get to the insurance side of this industry, nothing makes sense.

Frederic Laurier (04:47):
Basic microeconomics laws don't apply anymore.

AJ Loiacono (04:51):
This overly complex system ... I often tell people, how should drug pricing work in the United States? Go into a pharmacy, but don't go to the pharmacy at the register. Don't go to the pharmacist in the back. Go to the over-the-counter section and reach for a bottle of Tylenol or Advil or eye drops, and something magical happens in the US healthcare system. It doesn't matter if you're insured or uninsured. It doesn't matter if you work for the biggest employer or the smallest, it's the same price. And if someone walks in an hour after you in the same store, go figure, it's still the same price and the price won't change until real market forces, supply/demand, are going to change or have that seller change the price.

(05:35):
And what's so crazy in the pharmacy benefit system, the first time I started working with insurance claims or working with prescription benefit claims, it looks like drug prices change every hour of every day in every pharmacy for every drug. And this is a total lie. I just want everyone to think about what I'm saying here is everybody in the country is being lied to about the price of drugs.

Frederic Laurier (05:57):
And so, if we have to point to one factor that explains the discrepancies between the OTC and prescription drugs markets, it would be the presence of PBMs in the equation?

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AJ Loiacono (06:06):
Well, I was going to say, I don't want to make everyone out to be a bad actor. What I do want to point out is self-interest is the culprit here. And so, if someone says: "Hey, I can make more money if at my sole discretion I can just randomly change a price of a drug." Why is the variability happening? It's because what I call casino economics, which is you're playing probability and chance. So, if I have a 94% chance when someone comes into a pharmacy ... That's because the American public is so uninformed and this is such an opaque and overly complex system. If I have a 94% chance you're going to take any price I put in front of you, well... let's try out some different prices. So, you start to be creating thresholds of acceptance.

Frederic Laurier (06:56):
The only way to find if it sticks is to test it, right?

AJ Loiacono (07:00):
These are some of the largest companies in the world. You're very sophisticated in your economics and your approach to the market, but it has nothing to do with the real price of the drug.

(07:10):
I always feel sorry for the pharmacist. Full disclosure: I was the son of an independent pharmacist. They buy their inventory for a price and it's sitting on their shelf. There's a fair price that they're willing to sell it for but their price never comes up in this equation because again, the way pharmacy contracts are written in the United States when you start to deal with PBMs and insurance carriers is, again, sole discretion.

(07:35):
So, let's use an example. Let's just say a pharmacist buys a drug for $20 on a 30-day supply. Maybe I'd love to sell that for $30-$35. So, someone walks in with insurance, suddenly the person in charge is the carrier or the PBM and they go: "$50." Now, the pharmacist is like: "That's amazing. They sold that for $50. I should be getting $35 back. This will be great. We both make money." So, the first thing that usually happens is they bought the drug for $20, they're expecting $35-ish because they see the pharmacy charging the patient $ 50. They get reimbursed $18. So, they're already under water on the transaction.

(08:16):
Then, next month, they're going to get a bill and the PBM will play a game called clawback. "You know what? We did some math, turns out we gave you way too much money, so we're going to clawback more money. And that per script is an extra $1.50." So, now this poor pharmacist is even out of pocket even more money, which is what we call pharmacy deserts, where small independents can't compete anymore. They have no leverage or push back against very large entities. In addition, smaller operations are less efficient, but there's no reason why someone should be punishing them in this process.

(08:54):
And the economics are so backwards and they don't reflect real supply and demand. And that's what always bothered me, if it was an efficient market, buyers and sellers freely communicating on price. There's no communication, there's no efficiency, and it's a one-way system punishing everything downstream.

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Frederic Laurier (09:15):
How do these clawback clauses work? Are they included in some sorts of contracts?

AJ Loiacono (09:20):
Yeah. They're in the retail pharmacy agreements. This is between the PBM, the carriers and the actual pharmacies. We, Capital Rx, don't use clawbacks. We don't make money on drug spend. Our job is to be a great administrator, which coincidentally, this is where the industry began. It was: "Let me administrate your benefit on a flat fee."

(09:43):
The inherent conflict of interest that crept into this model was in the 21st century, when you suddenly have this notion of spread pricing, where the PBMs came up with an idea and they said: "There's no more administrative fee. We're just going to keep a little bit of money from drug manufacturers." When you start to make money on drug spend, you have an inherent conflict of interest because the more expensive the drug, the more money you make.

Frederic Laurier (10:09):
So, the clawback clauses were really aimed at getting rid of the flat administrative fee?

AJ Loiacono (10:14):
So, when you have a contract, you say: "If I ever believe I paid you, the pharmacy, more money than you should receive at any time, I can clawback the amount that I believe I am owed." There's no counterweight, because if someone goes: "I completely disagree." And they're like: "Oh, well, I can kick you out of network." In the US healthcare system, being kicked out of network could be the death knell for that pharmacy.

Frederic Laurier (10:44):
So, let's discuss another topic around drug economics. Not so much so about the pricing, but the concept of waste. We estimate the cost of waste in the US healthcare system to be roughly $1T. Are you witnessing firsthand a lot of excess spending on drugs? And how do you, Capital Rx, solve for it?

AJ Loiacono (11:04):
The first answer is yes, there is so much waste in healthcare, and drug spend is no different than any other segment of healthcare. Capital Rx doesn't make money on drug spend. Why is this important? Well, if I have a choice as a clinical pharmacist and we're going through your protocol of approval, and there's a $10,000 drug and a $5,000 drug, but they have the same efficacy, same access, etc. The $5,000 drug is less expensive, let's use it. Or, if there's a generic for $500 or $100, let's use that.

(11:40):
But if you make money on drug spend, you have spread pricing, you suddenly gravitate, unfortunately, towards the bigger price tag. And so, the first thing you want to do is what I call alignment. We get a flat fee per script, per member, per month. I don't care what it is, but I don't want anyone to say you've benefited from that decision. I think that's a horrible place to be in healthcare. So, that's the first part.

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(12:55):
The second thing is when someone is doing an evaluation, consultants and brokers, it appears as if the $100,000 drug saves you more money because you're getting a bigger rebate per script.

Frederic Laurier (13:09):
This is truly mind-boggling.

AJ Loiacono (13:11):
And unfortunately, there are people out there that maintain drugs that have very low therapeutic value and they're overpriced and there are generic equivalents available.

(13:23):
Let's do a more broad category example like metformin. Metformin has been around forever. The generic of regular metformin is $5 to $15 a month depending upon your dose, but manufacturers continue to print new and improved versions of metformin, so they can have an osmotic formulation, longer acting formulation. These are $600+, when I can get it for $5. That's just pure waste. Who would pick the $600 drug? Well, the person, once again, who makes money on drug spend. Back to alignment. If I make money on drug spend and I am your administrator, you're certainly tempted.

Frederic Laurier (14:07):
So, maybe let's spend a bit of time on your core offering and the role it plays. Maybe you can walk us through what a typical PBM workflow looks like and how your flagship product, JUDI, is able to streamline it.

AJ Loiacono (14:18):
I always say PBMs are administrators, they're managers. It's in the name. PBMs were created because there are hundreds of administrative tasks to sponsor a benefit. What are these administrative tasks? There's things like eligibility. Who's in the benefit? Who's out of the benefit? What's my out of pocket? What's my co-pay? You have formulary decisions. What's preferred, non-preferred? You have billing and reimbursement. All of these things a PBM must do. This is what a PBM is tasked to do, first and foremost, administrate the plan on behalf of the fiduciary or the sponsor of the plan.

Frederic Laurier (14:57):
They keep tabs.

AJ Loiacono (14:59):
Exactly. What we saw was the industry stopped evolving from a technology side. The vast majority of systems that process and administrate workflows for claim administration in the United States are 20, 30 years old. They're vulnerable. In addition, they can't evolve with new trends in healthcare, which is why, oftentimes, healthcare providers seem reluctant to adopt any good idea, because they don't have the infrastructure to meet those demands or ideas.

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(15:31):
For us, as an organization, not only if we're going to compete with titans in healthcare, we have to do it cheaper, better, faster. For us, we built our JUDI platform. JUDI is short for adjudication. She's the brains of our organization, and every single workflow in our organization runs on JUDI. My competitors have a very thin, narrow layer of electronic claim processing, and then they have all these bolt-on activities and they scale with people.

(15:58):
We took a very different approach. It was my background in supply chain software, working with my co-founder, Ryan, who's my CTO, to say: "We need to think about this as the journey from MRP, old supply chain systems, to ERP." And the ERP platform is really contemplating more work streams, layering in optimization and automation, reducing cost, creating efficiency. And this is core to everything you're doing. Remember, we do not make money on drug spend, so we're operating on a much narrower margin. You need to heavily rely upon technology. And this program, JUDI, became absolutely critical to our growth and our success in the industry.

Pierre Rikkers (16:39):
So, if I can step in. Again, thanks for welcoming me on your podcast. Coming at it from a FinTech perspective, the first question that comes to mind when I hear you describe your platform is that there are so many different players in the healthcare industry in the US. Right? Think about it in terms of different infrastructures, some of which are very antiquated and should maybe be upgraded someday or coded in different languages.

(17:00):
But my question is, how come there hasn't been in this massive industry, more of a unified approach to building a tech infrastructure that enables everyone to communicate with each other, process transactions centrally, etc?

AJ Loiacono (17:14):
The reason why, I think, are two sides to the same coin. The first one is, everybody's making so much money. Nobody's focused on this in healthcare. Let's just take pharmacy. When I started in the pharmaceutical industry in 2000, it was $120B top-line domestic spend in the United States. This past year, we went over $600B. Drugs can't stay branded forever. There's a reason why we have a limited patent protection workflow in the United States. They've never really had competition. If everyone has the same model, everyone's doing everything the same way. Do I really need to do something differently?

(17:57):
The example I give, that you might appreciate coming from FinTech is I remember when my poor aunt passed away and she left me 100 shares of Duquesne Power & Light. It was like $20 a share, and it was $2,000. So, I marched down ... I was in college at the time. I went down to the local Merrill Lynch. I actually had stock certificates, and I was like: "Hey, I'd like to sell this." And they were like: "No problem." And I'm expecting two grand and I get this check from Merrill Lynch for $1,700. And I was like: "Huh?" And they were like: "Well, we keep 10% of the trade and then there's some transaction fees. And here's your check." And I bought a car with it, so I was pretty excited at the time.

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(18:38):
But think about this, 10% of the value of the trade sounds criminal. And then turn of the century, you have literally Ameritrade, E*TRADE: "I'll do this for $59.95, $29.95." Charles Schwab and Fidelity, discount brokers get into the game, and they'll do it for $19.95 and $9.95. And then, Robinhood emerges and: "I'll do it for a buck." And now it's zero in my Chase account, and I'm like, what happened there?

(19:05):
I mean, there was an entire industry ... Think about this. There was this thing called a stockbroker, and he made money buying and selling stock, not institutional trades, I mean, mom-and-pop trades. Gone. This is claim processing on many ways, where this notion of charging $20, $30, $40 for every $100 script should be going in the opposite direction. We're going to see this same transition.

(19:32):
You can't have a market the size of claim administration or drug spend, whatever you want to call it, where you have so much self-interest and so much inefficiency. Competitors like us are going to emerge and drive costs down. You're also seeing regulatory interest and legislative oversight play a role in this, where people are like: "There's a lot of people complaining about drug spend. Maybe we should take a role in looking at this as well."

Pierre Rikkers (19:59):
Let me switch gears a little bit. Thinking about it again from my FinTech perspective, from a money flow transaction perspective, what infrastructure do you use to move money around? And how does that work? And what role do you play in terms of facilitating these money movements?

AJ Loiacono (20:14):
You're going to get a kick out of this, because I always say the financial industry is usually 10 years ahead of everybody else because there's so much money in it.

Pierre Rikkers (20:23):
Well, you're going to make me laugh there, because I don't think they're always ahead.

AJ Loiacono (20:26):
The first thing that blew my mind when I started to look at these workflows is, yeah, we process a claim and you basically are saying: "Who's the patient? Were they eligible? Who's involved? The MPI of the physician or nurse practitioner." In these hundred fields of information, you process a claim, no money moves. Well, you'd be like: "Well, it's going to move tomorrow, right? The next day? The next week?"

(20:50):
What you very quickly understand is the healthcare system adopted antiquated systems and never moved off them. If I'm a manufacturer and I sell it to wholesalers, and they sell it to pharmacies, they're like: "Hey, I'd love to get paid in six months." Wholesaler might be like: "Hey, I'd love to get paid quarterly." Pharmacy might be like: "Hey, I'd like to get paid every two weeks." You have insurance where you're typically billing every two weeks. Payment, you typically want 24 to 48 hours.

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(21:25):
The biggest part of healthcare is assembling all the information to validate these transactions, especially if they're government transactions such as Medicare and Medicaid. We should compress the supply chain. Everyone should be paid. There should be no lag in this. This will take lots of time to improve, but the first thing that we recognize is it starts with improving and modernizing that first part of the journey - the transaction, the collection of data, the validation of the different parties, as well as the rule sets that govern healthcare to have a high level of integrity to then release payments and transactions.

Pierre Rikkers (22:05):
It sounds like you should dust off that platform, or maybe keep on building what you're doing with Capital Rx and add that piece to the puzzle.

(22:12):
It looks like payment itself is not the problem here. What really baffles me is that I would imagine that businesses are in the business of getting paid, pay their supplier, so basically managing cash flow. And it seems to me that there's a little bit of inertia here and that nobody seems to care about how long it takes. But why is that? It doesn't seem that technology is really the issue here. I understand that someone may be happy to hold onto the money longer, but it's a two-sided model, right? There really shouldn't be one party that gets paid much faster than the other in a B2B relationship, or am I missing something?

AJ Loiacono (22:45):
It's definitely a little bit of technology because the systems are so old. They're very difficult to use: more modern security protocols, open API architecture to link into things faster, a lot of customized software are built out because when these systems were written, they were never designed to contemplate this type of ecosystem that exists today.

(23:08):
You are correct, which is, well, why are people hanging onto the money a little bit more? I was taught the buy side of any transaction controls the transaction. You've got the money, tell everyone to jump through my hoop. Healthcare does not follow this rule. The sell side tells everybody what to do, and they line up like penguins crossing the Arctic Circle, and just follow each other in the emperor's march.

(23:39):
I don't think payers understand the control they have. So, you do have the opportunity to change this paradigm, but oftentimes it's educating people that have, unfortunately, for 20 years been programmed to just believe they have to take what they're given. I used to have a sign in my old office that said: "He or she that is closest to the payer wins."

Pierre Rikkers (24:04):
It's fascinating.

Episode Transcript

Frederic Laurier (24:05):
Fascinating discussion from a FinTech perspective. I'll put my healthcare tech back on, and I would love to hear you on what I think could be a game changer on the clinical data side, especially as it pertains to pharmacy claims and medical procedure claims operating in two separate networks for the most part. Why is that that they have yet to come together under one unified platform? Similarly to the discussion you just had with Pierre on the potential combination of claims and payment processing in one single network.

AJ Loiacono (24:34):
There's a lot of different reasons why these workflows of administration and payment for pharmacy, medical and other services splintered and went down their own path. So, you could think of it as pharmacy uses its own system, if you will, its own codes. We use NCPDP D.0, and this became the transaction standard in the pharmacy business. And then, medical has its own set of codes, be it ICD-10, in which you basically transmit an actual claim sequence of eligibility and then information about billing and reimbursement.

(25:15):
Because of this splinter, you started to see people that specialize in pharmacy and people that specialize in medical. Also, pharmacy was like an offshoot that many people viewed as less expensive than even dental at one point. Go back to the 1970s, the average cost per script in the United States was $4. Nowadays, the average cost per script is $120 to $130.

(25:41):
When pharmacy started to expand, it became more and more important, and that's why we're talking about it as, well, why isn't it unified in this claim flow? This concept of unified claim processing, we invest very heavily in it. It's part of our mission, which is if there's inefficiency in claim administration, let's modernize it, unify it. A separate system is kind of tracking me as a patient on the medical side, and a separate thing is tracking me on the prescription side. Could that create service or safety issues? The answer is, heck yeah.

(26:16):
When a pharmacy benefit side gets the script, 9 times out of 10, it looks like it's a new start, it's a new patient. So, this poor patient has to go through the approval process all over again. The other thing is safety. We talk about drug-to-drug interactions, certain combinations you shouldn't take together. On the medical side, someone has prescribed you medication, and then I move over to the pharmacy benefit side, there's no way seeing what those drugs are, what therapies they're on. If you have a unified system where a claim is a claim, a patient is a patient, what you're going to be able to do is create efficiencies, create better service, create better safety workflows. A critical part of the future is bringing back healthcare to a core platform. It's going to take a while, but I think it's one of the most important projects for, I think, healthcare in the United States.

Frederic Laurier (27:15):
There will be one drawback. You'll have to come up with a new name. AJ, a true pleasure speaking with you today. Thank you so much for taking the time. I look forward to talking to you soon.

Episode Transcript

(27:24):
Thanks again for tuning into another episode of Crossroads by Alantra. An initiative that strives at bringing together our team of sectorial experts and healthcare leaders to discuss innovative technologies and themes that are reshaping our industry.

(27:38):
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Alantra – Global Senior Healthcare Team

Alantra benefits from a global senior Healthcare team with deep local presence, able to reach global strategics and investors

Rusty Ray
Managing Partner
rusty.ray@alantra.com

Franck Noat
Managing Partner
franck.noat@alantra.com

Justin Crowther
Partner
justin.crowther@alantra.com

Frederic Laurier
Managing Director
frederic.laurier@alantra.com

Guillermo Arbolí
Managing Partner
guillermo.arboli@alantra.com

Christopher Jobst
Partner
christopher.jobst@alantra.com

Matthew Wiseman
Partner
matthew.wiseman@alantra.com

Fabrice Scheer
Managing Partner
fabrice.scheer@alantra.com

Ignasi Portals
Managing Director
ignasi.portals@alantra.com

Anthony Harrington
Partner
anthony.harrington@alantra.com

Marcello Rizzo
Managing Partner
marcello.rizzo@alantra.com

Gianni Casanova
Partner
gianni.casanova@alantra.com

Drew Wightman
Managing Director
drew.wightman@alantra.com

Jonas Bauréus
Managing Partner
jonas.baureus@alantra.com

Sebastian Hougaard
Managing Partner
sebastien.hougaard@alantra.com

Alantra – Global Senior Technology Team

Alantra benefits from a global senior Technology team with deep local presence, able to reach global strategics and investors

Renee Shaening
Partner
renee.shaening@alantra.com

James Chapman-Andrews
Partner
james.chapman-andrews@alantra.com

Oriane Durvye
Managing Partner
oriane.durvye@alantra.com

Michael Lenoce
Partner
michael.lenoce@alantra.com

Oliver Parker
Partner
oliver.parker@alantra.com

Franck Portais
Managing Partner
franck.portais@alantra.com

Pierre-Alain Rikkers
Managing Director
pierre-alain.rikkers@alantra.com

Richard Sanders
Partner
richard.sanders@alantra.com

Daniel Lilliehöök
Partner
daniel.lilliehook@alantra.com

Aakash Bhasin
Managing Director
aakash.bhasin@alantra.com

Simon Roberts
Managing Director
simon.roberts@alantra.com

Lodewijk Sodderland
Managing Director
lodewijk.sodderland@alantra.com

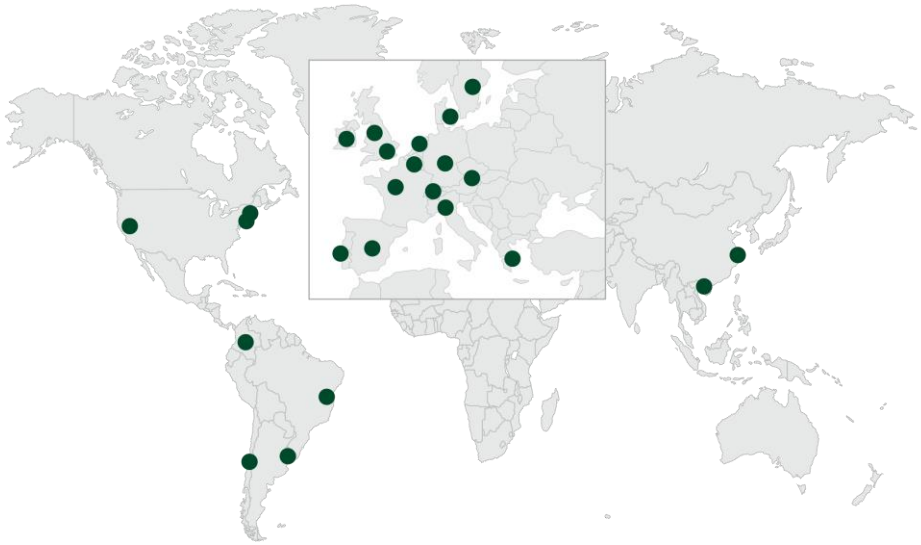
Sandeep Talwani
Managing Director
sandeep.talwani@alantra.com

Richard Zhu
Managing Director
richard.zhu@alantra.com

Julio Cardenal
Managing Partner
sebastien.hougaard@alantra.com

Alantra – Group Summary

Alantra is a global alternative asset management, investment banking, and credit portfolio advisory firm providing high value-added services to companies, families, and investors operating in the mid-market segment.



24 Offices Worldwide	550+ Financial Professionals[1]	100+ Partners[1]
$575bn+ Deal Volume[2]	1,800+ Completed Transactions[2]	1,300+ Clients Advised[2]

(1) As of Sep 2022. Excludes professionals from strategic partnerships where Alantra holds a minority stake (Singer CM, ACP, Wealth Management, Asabys and Indigo / Includes Corporate Services professionals
(2) Since 2013

ALANTRA

Possibility is in the ascent

Argentina
Austria & CEE
Belgium
Brazil
Chile
China
Colombia
Denmark
France
Germany
Greece
Hong Kong
Ireland
Italy
Netherlands
Portugal
Spain
Sweden
Switzerland
UAE
United Kingdom
United States