SHIFTING THE PARADIGM FOR HEALTH CARE—BENDING THE COST CURVE: UNDERSTANDING THE GLP-1 ERA

Josh Barro 00:19

Good morning, everybody. As Esther noted at the end of that conversation with Dr. Oz, one of the exciting new developments in medicine that people are grappling with over the last few years is the rise of GLP-1 drugs, a highly effective treatment for obesity. The first time we've really ever seen that. They're very exciting. They're producing a lot of benefits. They're also very expensive. And so there's a lot of questions about, how much do they need to cost? Who should pay for them? How do we make sure that we're getting good value out of them? And so that's why I'm glad that we have this really interesting panel here to talk about all of that. I'm with Lisa Stevens, who is the chief administrative officer at Aon, who has some interesting insights to share with us, looking at both the population of tens of thousands of employees at Aon and tens of millions of employees whom Aon has insight into employee benefits for. Simon Johnson, professor of entrepreneurship at MIT Sloan, also a Nobel Laureate in economics recently. Congratulations, Simon. And finally, Michael Ferro, who is the chairman and CEO of Merrick Ventures. He's a healthcare technologist. You may know him as the founder of eMed, and has some interesting insight for us on adherence and getting people to actually stay on these drugs. So, I want to start with Simon as we think about scoping large benefits— large costs here, what are we looking at in terms of the universe of benefits that we as a society are getting and stand to get out of this class of drugs?

Simon Johnson 01:44

Well, I think Dr. Oz actually hit a lot of the key points just now, Josh. Historically, when people's health improved because of better public health and also better private treatments, they became more

productive, they lived longer, their children—they got to see their children grow up so, you don't have the problem of dealing with orphans and so on. There were big social benefits to health improvements. Unfortunately, where we find ourselves now is we innovate very effectively in the United States. We invent a lot of new diagnostics and treatments, but the costs continue to rise, and the costs are born by private employers. They're born out of pocket, and, of course, by the government. So, Dr. Oz was talking about Medicaid expenses continuing to rise and what GLP-1s offer is the possibility, maybe probability, we're going to talk about that, maybe high probability, that this cost-curve could be bent by decisions that individuals will want to take, that companies will want to take, and that government may want to lead on, they want to emulate, and so on. So we could be back into a phase where health improvements lower our costs, healthcare costs, lower the burden of those costs, make us more productive, and have really massive social benefits. Well, that would be very exciting. How close are we to that? Lisa, what's your take on that?

Lisa Stevens 02:55

So there's been a couple of different panels today that we've been able to hear—some people have been able to hear about, but at Aon, we spend a lot of time looking at analytics and data, and so to compliment this, one of the things that we've looked at because of our clients having so many questions about GLP-1s and the use of GLP-1s and the cost—and we heard it again from Dr. Oz, like trying to navigate what benefits you provide to your colleagues, your employees, it's a big question. And so we have a database of 50 million people that are under—they're in businesses. So over 60% of all people are insured through their companies. So we believe—and I'm sure all of us do—that employers play a big part, along with the government in making sure that we make health care available to everyone, not just to the wealthy. And so in this database of 50 million, we found 139,000 people who've been on GLP-1s for two years and adhering to it. And then we had a digital twin, so a control group of another 139,000, and matched them up. And no surprise in the beginning, when you were first on a GLP-1, the cost goes up—the cost of the drug. All of a sudden, you're starting to feel better, and you start going to the doctor. And so the expenses, you see—so it starts higher. But then as the year goes on and when you go into the second year, you start to see the curve bend. You start to see health improvements: 44% improvement in cardiovascular issues, improvement in osteo—in less osteoporosis, and the list goes on and on of things—there's been benefits that we've seen from the data, and so there's a return on investment, but it takes time. And so what we're trying to do is help our clients navigate through this, make decisions about this benefit being available to their colleagues, to their family members, to create a healthier America, to create a healthier environment. And this doesn't even take into consideration absenteeism, productivity, engagement, but the holistic approach is also really important. And so that adherence piece has been something that we've been paying attention to.

Josh Barro 05:11

Yeah, that's— so you say, 139,000 people who have been adhering. There's all sorts of reasons that people go on these drugs and do not continue with them. Michael, what do you—what are you seeing? Because that's really a key space that you're in here is trying to track and improve adherence on these drugs. What does it take to actually get people to, not just, you know, go on this for a few months, but to actually stay on it and get, you know, persistent health benefits from that?

Michael Ferro 05:37

Well, the first thing is accessibility, making sure—right now, GLP-1s are a rich person's drug. There's bad behavior (inaudible) Even the counterfeit drugs that a lot of people are taking are still $200 to $300 a month. So right now, this is a white, rich, urban medication, and it's not getting to the vulnerable populations who really need it. And so the first step is accessibility. You know, getting—we need the government, we need third party sponsors, such as corporations, to put programs together. Now, rightfully so, like you said, the average GLP-1 user on the planet is in it for 90 days. 50% quit. And the reason for that, first of all, one is cost, accessibility of the drugs, and the next one is things like side effects. So the first thing we did at—when we founded eMed, we're working on COVID with Abbott the last few years—is we built this system that helped keep people on medication adherence by having a system that allowed people, very inexpensively, to access healthcare 24 hours a day with no scheduling. Instant access to life care. Now this is important if you're gonna have a drug like GLP-1s that are a medication for life. Let's first start with that. I hear people talk about this all the time. Is it 12 months, three months, six months? No, no. All the on-label is that this is medication for life that needs to be titration—titrated every 30 days. So the first people do is they're not—

Josh Barro 07:04

So just to scope that, that's how we should be thinking about this. There are—

Michael Ferro 07:08

You have HIV, you're going to be on drugs for life. If you have a heart failure, you're on drugs for life. You know, obesity right now the number one problem with GLP-1s in the world is getting reimbursement. I'm going to tell you the number one problem. Dr. Oz's ex partner—still partner— Oprah Winfrey describes it very well: obesity discrimination. The number one problem with people being on GLP-1s around the world is half the population believes obesity is a disease, but then we have the other half that thinks 'work out more and eat right you fat person,' and it's obesity discrimination, and that's really the biggest problem facing people being on this program. But the people that do get on the program, to your point, why do they leave? Things like side effects. So at eMed in UK—we launched in December, we have over 25,000 women who voluntarily get screened first with a little dose. They have

to take a little screen of blood at their home, which we oversee for them, send it to see where they're, where they're at, and cholesterol and kidney, thyroid function, et cetera. And they voluntarily did this, we thought we'd have 10,000 people in our study, they have to pay $200—about 160 pounds a month. To be honest, we thought we'd have 10,000 participants. We had 31,000 apply. We currently have 25,000 on it. And here's the great thing, we have something simple where you give them a reduced cost for these miraculous drugs. We have 98% retention, nine eight. It's 99% if you take out people with pregnancies, because we have to push them off for non-voluntary reasons to leave. And the reason is access, they check in every day. They have their blood work to know that it's changing them biologically. It's less money and right now, so you know, GLP-1s are more popular than cocaine in the world. They cost more, too, in some places, but they're more popular. And when you have this miracle drug that is the first preventative health product that people actually want—it is the first product in our lifetime that consumers around the globe, from America, the UK, to Saudi want this product. And it's about preventative health. It's about bending the curve. It's about wellness. We've never had this happen before. We have to take advantage of this.

Lisa Stevens 07:39

The one thing I— everything you're saying, I agree with. I do think employers play a key role in this—right—in terms of accessibility and the opportunity to provide it to a population. So 40% of America right now is dealing with obesity. It's a crisis. It's an absolute—it was mentioned again on the panel right before us—and so employers having data information to be able to, again, have their employees, be part of this, be able to find ways to help them to adhere to it with diet and exercise. It is a next generation solution, as we see right now, for a Healthier America.

Josh Barro 10:14

But so the funny thing about this is, this is this is already a really expensive phenomenon that you know, this has been a significant driver of health care costs in the US, just over the last few years, despite the, you know, the incomplete accessibility and the incomplete adherence. And so if you get better at getting people to adhere to it, and if you overcome some of that stigma, and if you bring in to employers the idea that, you know, this is part of a holistic health care package, then it gets even more expensive, right? Are we talk—are we talking more than $5,000 per patient per year on this? It's got to be more than that, right?

Michael Ferro 10:46

So— and I'll let Lisa talk about this—so in the UK and even here in the US, if people actually stay on the medication, do medication adherence, your costs go down.

Josh Barro 10:46

On net. They go down by more than the annual cost on the drug?

Michael Ferro 10:52

Yes, your overall costs go down. I don't have the Aon study in front of me, Lisa, but I think it was 7% improvement overall because these—this population is they go down.

Josh Barro 11:13

It's a 7%— I mean, what's the—what's the average health care cost per employee for someone who has commercial coverage? I mean, to overcome, you know, if it's even $5000 that sounds a little light to me, does that employee, on average have $60,000 in health care spends?

Lisa Stevens 11:27

So let's flip it a different way. Right now—and again, Milken data—we're spending one point trillion dollars a year on obesity, different types of diseases, which make up over 60 diseases, right? So if you think about the problem, and then you say, there's an application to it that we can—we have that can be, again, a holistic solution, where you're going in and in the beginning, again, the cost is higher, but over time you bend the curve, you start to see the employee having less issues around—the human being, having less issues around, again, cardiovascular issues, osteoporosis, pneumonia, diabetes type two. So there's—and there's still a lot more to be done, but the data is showing us that the return on the investment is absolutely there. You have to, you have to get past it. The last thing I'll just say is we have, again, clients who had their—they've been doing—they've been offering GLP-1s to their employees, trying to figure out, do we keep doing it into 15, 18 months? They need to have the data and information—this is what Dr. Oz was talking about—to understand, do we continue to do this? Because it's going to start to pay off, and so that's—being able to provide that information and data for them to understand the claims and understand what's happening with their employees, will actually, in the long term, be a good investment and will bring the cost down.

Josh Barro 11:28

Simon?

Simon Johnson 11:43

So two points Josh, obviously the amount we pay up front is going to affect the payback period, right? But the key thing, the really dramatic thing, and the new thing, is the curve changing its shape. That's the bending the curve idea, right? So that we can see. And presumably, what will happen, Josh—I mean, this we're good at in the US, is as this sector expands, and if it expands dramatically, if people really understand adherence, you'll get a lot more entry, a lot more competition. It won't be inject—it won't be an injection anymore. It'll be a pill and Michael's point is, it's like a statin. Well, statins, there's plenty of competition. If we find the right statin for you, you can stay on that statin for a very long time. It's good for you, and it's extremely cost—in terms—extremely cost effective in terms of, you know, that gets driven down to the cost of manufacture. So the dynamic, I think, is what's got our attention here, Josh.

Josh Barro 13:36

I have one more—I have a question to go to next. But first, I just want to flag for the audience—there's a QR code that they can bring up on the screen here. If you have questions, scan that QR code. You can send your question in. I'll receive it on this iPad right in front of me here, and I'd love to take some of your questions as part of this conversation. And so—the—with that longer run benefit and the longer run cost picture. Do we have a sense of, you know, if these drugs, you know, they were listing for $1,300 a month—but maybe a year ago—they've already started to come down and Zepbound, I believe the list price now is like $550 after consumer rebate per month. That's still substantial. That's still over $6,000 a year. But there's going to be more competition, maybe more entries, maybe pill forms. Do we have a sense of five years out from now, are we going to be talking about something that's half as expensive? That's one-tenth the price? What are we looking at in terms of a medium term cost here?

Michael Ferro 14:33

They're all coming down right now. Both Novo Nordisk and Eli Lilly have announced plans. We're working with both Novo Nordisk and Eli Lilly to have plans working with PBMs to get the cost down for the corporations that have programs, that have audibility and accountability, so the employers and the PBMs and the payers all can see a return on investment. So one of the reasons people have a problem right now is that they're gonna have to cover. So there's no way not to cover GLP-1s. So you most, most people that aren't—so GLP-1s have been around a long time. If you have type two diabetes, by law, you're getting covered. But guys, there's new indications that they're gonna have to cover for things like liver disease, kidney disease, cardio, sleep apnea. There's another seven on that the employers need to just manage this. It's too late to say we're not going to cover GLP-1s. I'm like, well, you could say you don't want to cover GLP-1s just for obesity but right now, Dr. Deanfield out of the United Kingdom, just released a report—maybe you can go get that his perception, his study, on people on GLP-1s, is that it

doesn't matter if they lose weight. This is really important. GLP-1s, because of their anti-inflammatory effect and the way they help you digest things like glucose, are changing the health curve right now for anyone on it where losing some weight is nice, but it's actually biological changes. So in the UK, the drugs are a lot less expensive. For the branded drugs, it's about 100 pounds a month, for the drugs in the UK already. So I can't tell you what's going to happen in the US, but I see it going in that direction for all the drugs. But the real issue, no matter what, is making sure that it's accessible. So our CEO is Dr. Patrice Harris, she's not here today. She's a former CEO of the American Medical Association, and part of her thing— she's our co founder—was how do we make this accessible to vulnerable populations in the US? And she's working with government officials and the manufacturers to help get this so that we can do remote GLP-1 management. How do we get these people who need it the most that make the biggest effect?

Lisa Stevens 16:50

And our data—we didn't, we didn't take the cost of the drug into consideration. So we were purely looking at, again, what was the—what was happening along the 24 months of the 139,000 and where were we seeing the changes, again, against the control group, against their digital twin, and the improvements in their health over time. So taking that out and looking at, okay, so what are the—what are the benefits? And that's where you can help the employers to make that determination of does this make sense for us, for our population with being able to provide the access to it, again, with the adherence and with a wellness program tied to it?

Josh Barro 17:31

Simon?

Simon Johnson 17:31

I think there's a very important question coming for state Medicaid programs (inaudible) So state Medicaid programs, I think, have a very interesting proposition before them right now, because they're dealing with a lot of people who have many of these co-morbidities that Mike was talking about, and this is a very big cost, which is incurred by—born by the state and is also shared with the federal government. If they can get access to these medicines at a cost they think is reasonable, then they have the potential of extending lives, making these people more healthy, and actually having them survive until they're eligible for Medicare, for example. And that's a pretty big, I think, motivation for the states to think about this. And of course, that's very vulnerable populations that we're talking about.

Michael Ferro 18:14

Well there's a new effect too, that I was talking to Dr. Oz about a few months ago before he was confirmed, is that if organizations, governments included, tell people, "hey, we want you to get screened to get this medication, to get this reduced cost for this miracle drug." Now, here's the issue, we would love to get everyone screened in every country, because, as you know, screening people, you find things. So let me tell you real data of the people that voluntarily screen right now, 3% of them have critical issues that we find in their blood work that we need to send them for immediate care, 3%. 91% of both US and America have other comorbidities besides obesity, but we find things like thyroid issues, liver issues—people had no idea. If we could start people to do screening, you know, inexpensive at home, taking basically a physical, giving a little blood work with about 10 panels—if we can start doing this in countries all over the world, from the UAE, the Saudi we're in talks with, to India, that—that will bend the curve just because people starting to do any type of, you know, preventative medicine is a big change for population health. This is the first time we've had this opportunity—in America and other countries, they've been trying to pay people to go do a checkup and it hasn't worked.

Josh Barro 19:37

So one interesting thing about this idea that you have costs that start high up front, and you produce benefits in health—that maybe over a lifetime and are certainly over a period of several years—is that you have a question about who pays and who benefits. So if you have an employee and you're paying for a GLP-1 drug now, and they're going to be healthier in five years, they might work for somebody else in five years, that's a different payer who is going to be saving money there. You also have, you know, if there's a lower disability burden, and that saves the government money, and the government's not the payer, that's a fiscal benefit, but the fiscal cost is not there. You can also get the reverse version of that. You have someone who is a Medicare or a Medicaid patient. You have a government expenditure. You have certain privately captured benefits. I'm interested in all of you, but especially to start with Simon on this. What does that tell us about—should we be thinking differently about who should pay here? I mean, is this something that should be, you know, is this a fiscal cost that should just go on the government because of the really long-range nature of the benefit?

Simon Johnson 20:34

I'm laughing, of course, because this is the kind of—you know, the question that would kill initiatives—trying to change the payment structure in the US healthcare system is very, very difficult. I think Josh, what's interesting is that sure, we could probably come up with a better scheme. Give us 20 minutes. But working with what we have, you can see agency for individuals. You can see motivation for companies. You can see state Medicaid agencies and authorities wanting to get involved. And so I think there's a path forward that may not be ideal, may not be as fast as we want, it may not drive as much innovation, as quickly as would be ideal, but I think it's this—it's a preventive type of program that

people are opting into, and it's going—they're going to see benefits immediately as long as they adhere to it. I mean, the adherence, I think, is the key thing that we all want to be stressing here today. If you don't adhere, you incur a lot of costs, and you don't get any benefits, and then you get a backlash against this kind of program.

Josh Barro 21:27

Lisa?

Lisa Stevens 21:28

It's a fantastic question, right? So as an employer—so as the head of HR for a 66,000 person organization, having data and information to make the decisions about what benefits are you going to pay for? What do you need to offer to—and what helps with retention of your employees too, and longevity of your employees staying with you? And so those are the right questions to ask. And so for us at Aon, we made the decision to provide GLP-1s to our employees in the United States and their family members, and we believe that we will have a healthier workforce. And we do believe that you have to have adherence, which is why we're partnering with eMed to help us with the adherence for our colleagues and their family members. But I do think that that data and information depends upon the organization, like you said, and so I'm speaking directly about employers to really determine that. And it goes back to where do you make your investments? And one of the things that we have—that we've used—and we use inside of Aon, also for ourselves, is we have a health risk analyzer that helps you determine what are your claims inside of your organization to determine where is the best place that you should be putting your benefits towards to have a healthier workforce. Again, to get that return on investment. In this case with GLP-1s, we see it as a next generation opportunity for us to create a healthier workforce inside of Aon.

Michael Ferro 22:50

So I've actually heard this from HR—you're exactly—hey, we have people who leave. You know? Why should we do this? Et cetera, right? So first of all, let's just be in a financial thing. Recruiting people is very expensive and I've told everybody the cost of doing a GLP-1 program. Once again, you all have GLP-1 programs, you all have them. You just don't know it, because everybody can go to their doctors. The big thing that's happening is doctors can write scripts. If you don't have a controlled program, you have an out of control program, but you all have it. But here's what happens. People put a value now—with compounding going away, you all have a giant issue the next 90 days. I'm going to explain this to you.

Josh Barro 23:38

I assume most—

Michael Ferro 23:38

You know what compound counterfeit GLP-1s—like you've seen them, the $2 to $3 a month—where a lot of your employees today have been like, I'm just gonna go pay $200 out of pocket and go on a program. I don't know if it's fentanyl and sugar water in there, but I'm still gonna go do it. You know, there's been hospitalizations and things over these counterfeit products. But here's what's happening. Get excited for Q4 guys, because all the compound counterfeit drugs are running out, and there will still be bad guys making it.

Josh Barro 24:12

There was a change in the FDA regulation. FDA regulation allowed—and now it's not allowed.

Michael Ferro 24:16

To not allow this anymore. Well, guys, people can be like—even with all the price reductions, it's going to cost people $600 to $700 a month to go do this. Just so you know, if you have people to make $100,000 this is 10% of their pay. They still want these medications, and they're going to go to an employer that does this medication. People don't understand. I'm talking with Aon and other benefits consultants. There is a traumatic thing that's going to happen this summer and fall, when all these employers that need employees need help and to the some of them, this is the most— go on TikTok, go on social media. Go see people who are doing GLP-1s and how it's changed their lives. For the first time, food noise, being able to wear clothes, going on vacations, have relationships. You all have a million and a half of those people coming to see you saying, I can't afford it. What are you going to do? What they're going to do is this—I've told this to Novo Nordisk and Eli Lily. They're going to go find ways to either go get more dangerous back alley black market products from China to try to stay on it if you don't help them—you're going to have sicker employees—or they're going to go find an employer who takes care of this, because they look at it as a $10,000 a year benefit. So you need to make it at a cost. (inaudible) Get the credit from them, even if it's for seasonal workers. Some companies are talking about getting seasonal workers with this promotion this year—we cover GLP-1s because it's that important. Do not—it is the number one thing that I've been hearing from every CEO, CFO at their companies—Aons explained this to me, (inaudible) explained to me, other people explained to me today, you all have an issue. You need to figure out how to manage it. It is a tsunami coming, now what they think is going

to happen at Novo Nordisk and Lily—great companies—they just believe people are going to suddenly find $600 a month out of their pocket and pay for it. They actually believe that. Maybe they're right, maybe people are going to give up their car, you know, less food on the table, maybe move into a smaller house, but that is very hard for most Americans to spend $600.

Josh Barro 26:36

I want to ask about a couple of areas of the benefits and the costs that people are trying to scope here. One is—Lisa, you talk about the reduction in health care costs, but people are looking for a broader set of benefits beyond just health care cost improvement. There's, you know, this idea that you'll get higher productivity, fewer sick days. Of course then there are, you know, subjective benefits to the consumer also, which I think are difficult to measure, but are you—do you have— are there numbers that you can start putting on if your employees are on GLP-1 drugs, not only do they save on some of their non GLP-1 health care expenditure, but are they showing up to work more? Are they doing better work?

Lisa Stevens 27:10

So we're way too early into offering it—we started in December. And our population numbers are smaller. It's the—our US population so it's not large enough. What I will say is that we're looking at—have been way before, you know, GLP-1s came out—we've been looking at the mental health of our employees, which is—you couldn't even say the word mental health five years ago—we look at, we're looking at the mental health, physical, emotional, financial, all of those things, and we're measuring it. We're measuring how are they doing. Because we know you have to pay attention to the entire employee. We also know that this generation expects very different things from their employers than before. And so the intention on how and what we do and then measuring it is super important, and same for any employer. So you can talk about Aon at 66,000 but we're helping employees all—I mean, companies all over the world with millions of employees, and trying to determine, again, where do you shift your costs to be able to have the most productive, engaged workforce you possibly can?

Josh Barro 28:18

Simon, how do you think about measuring that? Because, I mean, again, these are big fiscal questions. When you know the government is deciding, are we going to cover this in Medicaid, to be able to put a number on that, I think, you know, sort of helps people figure out what's worth spending money on.

Simon Johnson 28:31

Let's come to the fiscal question in just a minute. I think that the (inaudible) is measuring the productivity gain, not just the engagement, not just sick days, but also Michael's thing, which is, like, the person is massively distracted, the person gets engaged in high risk behavior, you lose the person. I think that's the frontier, and that's what a lot of people are working on right now. Josh, that's a really important number. We don't know for sure. We know this—we know the sign of the effect, but the quantity is going to matter. In terms of the fiscal effect for government, this is, I think, a related but different calculation, because from the state Medicaid point of view, you want people to be healthier for longer. You'd like them to get off Medicaid and have a higher income, obviously, to do that—so productivity is going to be related—but you definitely want them to live to be healthy enough to go to Medicare. Now, when you think about it from a Medicare perspective—so Dr. Oz is looking at both. He's got a very tight job there. Medicare, I think, is also going to benefit from this. Again, the question will be, you know, is it a 45 year old who is less sick lives now to be 65, 75—at the end of your life, Medicare still owns a lot of that cost, right? So that's not going away. Let's not kid ourselves. And, Josh, there's going to be implications for Social Security, right? We have to confront and we have to think about that. People are going to live longer, happier, healthier lives. That's a good thing. Well, sure, but they're going to need to draw on Social Security for longer.

Josh Barro 29:48

The sign on that fiscally, I think, is uncertain, right? Because if people—if extending life add social security costs, but maybe we also extend their working life, and that actually improves—I mean, how are we going to measure that? Is there a way to—how do we develop a view on what the sign is there?

Simon Johnson 30:02

That's going to take longer and obviously what's going to happen on the working life is, what do people choose to do— now you're healthier at age 62, do you choose to work to 72 or do you choose to retire early and enjoy your 60s in a different way? That's a calculation we just haven't seen play out yet. But this is presumably, again, another frontier for research.

Josh Barro 30:21

I also—I want to put some practicality to— we've talked some about the importance of adherence. What does it mean in practice to improve adherence there? Michael, you told me something interesting before the panel, which is that as expensive as these drugs are, a lot of the cost is actually in the management around it, in terms of doctors appointments and labs and that sort of thing. What is what does it look like to try to keep someone on these drugs, and how do we do that in a more cost effective way?

Michael Ferro 30:45

Well, using AI products and telehealth products and doing things remotely is one of the biggest cost reductions. So both in the UK—the UK right now, one of their biggest issues—they have the cheapest GLP-1 drugs in the world. And they came out with a study—I think Lord Darcy's here I heard so I'm gonna go see Lord Darcy—well, they said it will take over 100 clinical hours a year to manage someone on GLP-1s because they have to go get screened, see a doctor, monthly clinical checkups, (inaudible) screenings dealing with side effects, you know, all these issues that happen. And we said, well, if you use, you know, AI, use a platform, use telehealth, use asynchronous healthcare, we have the cost down to about 12 hours of management, and people are getting the same level of service. The other issue that comes about is the amount of time it takes people right now, today in the United States of America—it doesn't matter how wealthy you are—you go see your doctor, you have to go to Quest labs to get your blood—these all takes hours. You then have to go find your drugs for the most part—which is another fun thing, to go find if CVS or Walgreens has them—take your time out, make sure you're getting your prescription every month. It is a very hard system with all the money in the world. So we figured out the way to keep adherence is not just making sure they check in once a week, but you have to get rid of all these friction points to make sure there's cold storage, that cold chain where something that needs to be refrigerated—like the vaccines and all the COVID products work—so this is all built now that you need to get people home delivery with a product. They need to get it ahead of time. They need to have titration being done. They can't—no one can be on drugs for life if it's really hard, it doesn't matter who you are. So it's not just about them. Now the accountability of them checking in two to four times, you know, a month, doing a screening at home every six months—they're willing to do that if it's subsidized. By the way, they're willing to do that if they just like the program in the UK. If this makes what—what's really important is what we think we're doing for third parties—that we're the only company in the world that, if you're gonna do GLP-1s with the eMed AI platform, we make you do a blood screening, where you have to do 10 labs to begin with. And at first, everybody's like, why? I've heard this from the CEOs of Lilly and Novo Nordisk, because they think that creates friction. I go, 'it creates friction at the beginning, but it keeps them on for life,' because the moment you have a report card, you, not just the company or your sponsor, of biological changes that are irrefutable, that are happening, that makes you stay and do medication adherence. Once you get your own report card—and that's what we're finding, what looks hard at the beginning, you get people through it, that changes everything. And by the way, that's the report card Dr. Oz and President Trump need too. If we're going to do this for Americans, I am very supportive of the administration's current—they blocked it being approved right now— the way they were going to distribute drugs in the classic way, and they're trying to figure out a model to have accountability. And we are supporters of what the government's doing.

Josh Barro 34:01

Lisa, what role are employers thinking about taking in this when they're, you know—are they assisting with access? Because, I mean, I personally, I've been on Wegovy for almost two years, and the amount of hoops that I jump through for that, on the phone with pharmacies, on the phone with payers, and the price—you know, one month, it's $1,300 the next month it's free. The next month, the insurance plan has changed over, and the doctor's office has to file all the same paperwork again. Then the pharmacy doesn't know how to fill it and get the right payments from Novo on time. And so it's the amount of—the friction that is there, I'm sure, is causing a lot of people to drop off, either because of the amount of work that it is or because it's impractical for them to not know what the drug is going to cost from month to month—are our employers play playing a role in easing that?

Lisa Stevens 34:45

So, in the data, again, that we shared on the 139,000 were people that adhered to it for the two year time frame. So and— like you said, the hurdles and the challenges. So I'll talk about Aon because we—our experience before we changed our program, and I'll talk about—a little bit more about what Michael did. But all those things are true, like the hurdles that people would have to go through, getting an appointment, getting a prescription, getting the right dosage, dealing with the side effects, dealing with the challenge, the mental health challenge, all the things that go on in that and so we made the decision in December to roll it out to our colleagues, again, in the United States, and have eMed help us with that. So it's the weekly—it's the weekly check ins, it's making sure they're taking the drug, but it's much bigger than that. It's much broader than that. It's constant communication on here's what's happening in your body, here's things you need to understand. It's wellness programs, it's ideas on things to do. And then Michael, I'm going to hit—pitch back to you, though, on this that we—I think the—our objective is that we're a community supporting our colleagues and their family members to be healthier, and we believe it'll be—they'll be more productive as a result of that advocacy. It's a lot of those things. But one of the things about SheMed, which again, is B2C, very different than the—you know, what employers are doing but is the community that SheMed can be—has created. So I think about the people that were taking the drug before we had the program at Aon and they didn't have the same navigation. One of the things that that I've been so impressed with with SheMed in the UK is that they've created a community for these women to be able to talk to each other about the things that they're going through, and then have doctors that are coming in and providing them. That's the power and the good use of social media, Michael, that I think is very impressive in terms of an impact on why you've had, I think you've said 97% or 98% of people have stayed with the program.

Michael Ferro 36:46

SheMed's being run by a couple of 20 somethings that are doing it, and it's a brand we're going to bring around the world. (inaudible) SheMed brand and eMed is coming too. Yeah, we quietly, you know, work with a certain gender group and figure out what their fears they have. What we found when we did a trial at eMed on GLP-1s in the UK a year and a half ago is that we just launched these—get 1000 people

on board. It was 87% were women that want to do GLP-1s. And that's how SheMed got launched. And now, you know, I once—you said something about—congratulations, by the way—

Josh Barro 37:06

Thank you. I mean, it's great. I'm 30 pounds lighter, and it's like—the mental effects are crazy for me. It's like—it's funny, Amy Schumer has this bit where she talks about that—you know, women will say to her, I forgot to eat lunch today. She's like, I've never forgotten to eat lunch. What I have done is eat lunch at 2:30 forgetting that I already ate lunch at 11:45 and like, that was my relationship to food, and it completely changed. Like, I actually now have this experience where it's like, oh, it's 1:30 in the afternoon. I haven't eaten anything today.

Michael Ferro 37:34

Like (inaudible) so yeah, how has been your experience on GLP-1? Would you mind if I ask you a question on your titration? Do you know what level you are on?

Josh Barro 38:02

I'm on the maximum Wegovy dose of two [inaudible]—

Michael Ferro 38:04

They're gonna go up with that. They plan on coming up with that on Wegovy to help be competitive with that. It's coming very, very soon. That Wegovy will be available at higher doses, same price—so I was there at Novo Nordisk last week with their team. So that's coming. I mean that it's like—by the way, that's the story I constantly keep hearing, is people are on it—but the other story I hear is—so I was on the drugs, except I did my blood screening and I have a thyroid issue, so I had to get off off of this little eMedtest. I thought it was wrong. I was demoing it for people like you, and they sent me the results, and it turned out I have to have stop the medication until they fix my thyroid. That's okay, by the way. That is good when that happens. This has happened to multiple people who, while they're trying to take GLP-1s and look better, I'm obviously obese, and you know, I'd love to be less obese, but that's one of the problems I have, is I can't be on the drugs right now, but that's okay. You're gonna have that in your population. But the thing about the $1300 I, even being the founder of eMed with access, was paying about $1,300 a month for the drugs, and I have United Healthcare's coverage—and our company—finally, we start offering to employees, and we have to make it a supplemental benefit at our own company, because we can't work, the PBMs don't want to work on this right now. So that is—there's—I

can't imagine a world in two years with people like Aon, who are going to go help companies get over this game everyone's playing—which there's been bad behavior by the users going on and off or giving them to their cousin and not taking drugs or reselling them on Craigslist. That has happened. I agree. So we can fix the fraud, but when you suddenly tell people there's a $100 to $200 copay, and you make it that they're just getting the drugs, and this is just swept out of their paycheck, and they know it comes every month, and we stop the games—I can't imagine the benefits there's going to be in the United States, where suddenly Robert Kennedy, you know, doesn't have to be as stressed out as in two or three years—and I think it's that soon—we can actually bend. Imagine if all the benefits consultants, all the big companies, and the government worked on this. During President Trump's term, we could literally stop every year the cost of health care has gone up. Just imagine if we stopped, and we bent the curve in three years. Just stopped—how that'd be so different for all the problems we have, shortages of doctors and nurses, and costs in America, and fraud. Just think—imagine if we just make it easier and have everybody participate in the cost, but everybody do the program right. That's why I do—that's why I'm doing this, guys. I've been a very lucky fellow. I've had lots of successes. This is the first thing—we have a Nobel Prize winner on here. He's not happy to mention that, but Simon is a Nobel Prize winner. But I think there are people winning Nobel Prizes for the miracle of GLP-1s and how it's going to change the world. It's that big.

Josh Barro 38:06

Oh, really? I want to take some of the questions that have come in from the audience, and one is a question that I think we hear a lot, which is, shouldn't we be focusing on the root cause of obesity instead? It's clearly a lifestyle and dietary issue, not a GLP-1 deficit that causes it? Is it more economical and healthier to address lifestyle rather than cleaning up the mess after the fact? And so, you know, the—in terms of effective, you know, I mean, you can—it's easy to explain to people that if they exercise more and eat less, they will be lighter. Are there effective interventions that actually change, at a population level, the rate of obesity without medication like this?

Lisa Stevens 41:50

So, 2012 obesity was—it was—it's a chronic disease. And I'm going to go back to the statistic, the Milken statistic of we're spending $1.7 trillion a year on obesity issues and so—and back to where Michael started, with the stigma and the shame that's associated with obesity—which I think it's important that we would provide people with facts and information—what we've seen, again, it's just data, but the data that we're putting in front of our clients is that, again, 139,000 people against a population of 50 million, a digital twin matched up against it, in year two of being on the drug and adhering to the drug with diet and exercise, it's a generational change for the world, and so far, that's what we've seen from the data.

Simon Johnson 42:50

We don't see this about statins. So you could just say—you can lower—I said to my doctor, don't worry, I can lower my cholesterol with diet and exercise. And so he's like, yeah, sure, go ahead try, right? So I take a statin, I had to find the right statin, right? And, you know, I don't think it's—I don't think it's a character flaw that I have. I think it's just a drug that really helps you, and it would—the GLP-1s are going to help a lot of people with these comorbidities. Yeah, there's a question of cost, but if we innovate, and if we drive into a space like this, we know what happens. It's like statins, right? The cost comes down a lot, but you have to do it right. And the adherence piece is absolutely critical, because if we have programs and spending without adherence, either in the private sector or in the public sector, you're not going to like the results, because it'll be about the adherence failing, then there'll be a blowback. So it has to be done properly, carefully, has to be measured, and we've got to capture and look at these productivity effects, both the direct ones for the individual and for companies, and then I think we're going to see the pathway forward.

Lisa Stevens 43:45

And I would just say—similar, I mean, I think about—you know, again, mental health wasn't something we talked about five years ago. You have to talk about it as an employer now. Menopause was a bad word. Like no one wanted to talk about menopause and the impacts of menopause on women, and that's an obligation of employers to understand what you're providing to women during—the impact that that has on the on the workforce. And so I don't think—I think this is a similar situation where people need to be given the facts and the information versus basing it off anecdotals.

Michael Ferro 44:18

So lastly, Robert Kennedy is on this, you know. We have 10,000 ingredients in our food chain, right? We have plastics, you know, micro plastics. We've been poisoning—we've allowed the tobacco companies to take over the food industry in the last 40 years. We've been getting poisoned. I don't care if you're a billionaire, you know, we—we're fighting science with science right now. And I don't listen to this, I don't want to hear it—the charlatans of wellness that I call it. It's the sort of the weak to keep telling us, oh, just go do Weight Watchers. Everything worked out because nothing has worked in these—none of these legacy weight loss programs, wellness programs have worked.

Josh Barro 45:04

We have another audience question that's again, about the cost-benefit here. And so Mark Hyman asking about, you know, the saying he sees about 10 to 20 cents of savings per year for every dollar

spent on GLP-1 drugs. There has to be in this, you know, as—whether it's governments or whether it's employers as we're making long run decisions about who's going to pay for this and how much they're going to pay for it. The cost side is going to be really key to that question. So some of that is about, are there ways to draw on AI and have the administrative aspect of that be more cost effective? But a lot of that is still going to be the direct pharmaceutical cost. Is there a number? What price does this have to come down to per month for this to pencil and say—you know, as Simon notes, that we have a complicated payer system, and it's not always the right person paying, that we have the system we live with—but is there a number that this has to get down to for that to work—where, you know, we're going to say, this is going to get thrown in with all the other pharmaceuticals, and employers and the government are just going to pay for it, and cost is low enough that it makes sense.

Lisa Stevens 45:05

I would just say, I hope so, right?

Josh Barro 45:10

But I mean, what is that? You know, is 100 pounds a month is what? $120? Is that low enough? Are we going to—are we going to get there?

Michael Ferro 46:08

So here's the funny part. I'm going to use the UK as an example. We don't understand—we talked to NHS, and we think you know, people like Elon Musk would say, at that price they should be putting in bows and arrows and just shooting everybody with Ozempic. He's actually said that, so even with the low price drugs, there's obesity discrimination, and at 100 pounds, everybody—they should give this to everybody in the UK who wants it—at that price point. The ROI is incredible, but it's still not happening. It's like I told everybody, you could go offer certain people, here's $100 for $1 bill. And a lot of people won't take the $100 bill. That's where we are with GLP-1s, because I've now seen it in the UK. They have the price. They have the intellectual capacity, you know, they're one of the greatest countries in the world. And the price is not it when you have obesity, discrimination and ignorance, and people who have legacy—I don't care if they have their weight loss, their bicycle thing, the walk-a-thons—who are out there still saying, 'Oh, drugs are bad. You should do this on your own, and it's your fault.' I believe obesity discrimination. It's not the price of the drugs. I don't see that at all. It's obesity discrimination.

Simon Johnson 47:32

I think it's going to become a cheap pill, Josh. I don't know when, because that's a result of these dynamics we're talking about—adoption, amount of entry, the scale, what's the business model that succeeds? But I think it's got exactly the hallmarks of what makes this industry so compelling and yet, also sometimes so frustrating. You make a lot—you allow people to make a lot of money when they innovate, and then you allow you push for entry, but you do let them extend patents and so on and so forth. So is it 10 years? Is it 20 years before it's super cheap? I have no idea. But the dynamic is there, and also this—there's an adoption logic for individuals, for companies, and for some elements of government in this country and other places. So we're going to be learning, and we're going to be measuring better, and that'll help us calibrate the way forward. So ultimately, we'll look back, we'll say, why did it take so long? Kind of embarrassing, but, you know, we'll get there.

Josh Barro 47:32

And then, final question I want to take coming from the audience, and I want to start with Simon on this—is you open by talking about the bending of the cost curve and how we're hitting upon a health care intervention that, in addition to extending life, looks like it has the potential, at least in the long run, when costs are lower to lower health care costs. Are there other things that you see coming on the horizon that are appealing in the same way? The questioner asked about dementia, cancer vaccines, mental health. Are there other areas we should be looking for where we think that there might be innovation that actually saves money in addition to extending life?

Simon Johnson 47:35

Well, the one that comes up all the time, but it's somewhat magical in its discussion, is AI. That artificial intelligence will somehow change something about how we interact with healthcare. It'll change how we think about our lives, our benefits, and so on. But I think the problem with that, Josh, is almost always—it's pretty nebulous still, and I think something like this empathetic AI that Michael's using where you actually—you're not really replacing the provider with AI at all, you're putting some power in the hands of the patient. You're making it so that the patient can get access, can get advice 24/7, for example. You're making it so that you can get the drug at the same price every month easily. So it's actually—you might call it AI, but I think it's actually just making people's lives easier, that their lives are the patients, the individual people and Dr. Oz, this was, I think, the first thing he said this morning, which is he wanted to take up his current position and pursue his career, I think because he's interested in agency for people. So people having agency relative to this extremely complex healthcare system. So I think that some elements of AI and some elements of making life simpler for people and easier to understand and helping them make their own empowered choices that, to me, is not super high tech, but that, I think is the right way forward.

Josh Barro 48:53

Lisa, do you have a last thought?

Lisa Stevens 49:04

I would just say that 40% of the United States is struggling with obesity. It leads to 60 other diseases. There is a ma—or condition, there is a massive opportunity for us to be focused on that. Our population is over 50% female and so—and we know that it was 2016 before we even did trials on female mice. It was always only on male mice. That was 2016, that was nine years ago. So there's a lot of opportunity for us, as we move forward in this next generation of health to really think about, how are we holistically addressing things and making sure we're paying attention to population health and helping people to make good decisions and organizations to make good decisions.

Josh Barro 51:00

Okay? I think we can leave it there. Thank you everybody for joining us and thank you for the interesting conversation.

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