PAVING A NEW PATH FOR HEALTH CARE: ACCESS REIMAGINED

Announcer 00:02

Please welcome, Managing Director, FasterCures, Milken Institute Health, Sung Hee Choe.

Sung Hee Choe 00:18

Good morning, everybody. I have the honor of welcoming you all to today's session at the Milken Institute Future of Health Summit, and I want to give a personal thanks to Ana Rita. Many of you were here in the room when Ana Rita spoke and really reminded us why we are all here today and when we convene under the banner of "in service of better health," we cannot talk about innovation, investment policy, if we do not ultimately remember the people in the communities that we want to serve. I am very excited about this morning's plenary, where we were bringing together leaders across health and in government to answer the question that Ana Rita, or the urgency that Ana Rita posed to us: How can we deliver a health-care system that serves patients and their families in the most urgent way possible? And I think when we walk away from this room and when we try to convene all of us together at the Milken Institute, what we want to encourage you and inspire you to think about is, how can we move forward together? Who are the people who we can partner with and engage with and commit that we want to have a better health system for patients and communities and for all of us? But first, before we kick off, I would like to also give a thanks to the Milken Institute partners and supporters without whom we could not do our year-round work. Thank you.

Announcer 02:15

Allowing us to achieve our mission of accelerating progress on the path to a meaningful life. [Music]

Announcer 03:41

Please welcome CNN reporter Sarah Owermohle and the panel on "Access Reimagined."

Sarah Owermohle 04:11

Hello everybody. Good morning. I want to apologize ahead of time, I didn't give myself time to write on my note cards so I will be looking at my phone. It's not because I'm uninterested in what you were saying. It's just because that's what my questions and notes are. But I want to start with something topical this morning. President Trump, in a few hours time, is reportedly going to be announcing an agreement to make GLP-1s less expensive and more direct-to-consumer with two of the biggest companies, of course, that make branded GLP-1s. And so I actually want to start with you, Neil and Amazon, asking about that, and how we think about these products in general. Is the future, now that GLP-1s are a direct-to-consumer product, people were already buying them, compounded from different telehealth providers, for instance.

Neil Lindsay 04:59

Well, good to be here. Thanks for having us. Firstly, what I'd say is our mission is to make it as easy as possible for patients, customers, members, to find, choose, afford, engage with whatever they need to get and stay healthy. Whether that's a product or medication or professional. So if those things, if GLP-1s, are available, or other medications are available direct-to-consumer, of course we'd like to make that easy to do so in a properly, you know, a medically appropriate manner, with all the right consultation and advice from clinicians and so forth. So I certainly think that the, you know, the opportunity is interesting to—or the need is there for patients, and the interest in the products are there for patients, and certainly we would want to serve that need.

Sarah Owermohle 05:45

Deb, do you think that this is overall reflective of a shift in how consumers want to receive their medication, and you know what interests them in different products?

Deborah Glasser 05:56

So thanks for having me, and thanks to the Milken Institute. I'm Deb Glasser. I run Specialty Care at Sanofi. I'm the head of North America and the US Country Lead, and we are not, unfortunately, in the GLP game. We have a big diabetes franchise. We make a lot of insulins, but the DTP/DTC platform is interesting. I think it fits in a certain category of products like GLPs, where you have true consumer demand and a price point before and now that's accessible for more and more Americans. But I think, you know, Dan probably has a really interesting take, because taking the payer out of the conversation creates all sorts of

interesting, possibly misaligned incentives. Patient safety is possible, but I also think I'm a large employer, and how do I think about, you know, a net price that's maybe less than a sponsor what I'm paying? So it's a really interesting thing to watch evolve. I think it's absolutely part of the growing obligation that patients are paying for their health care. But I don't think it's a panacea for the larger topic that we're talking about, which is, you know, how do we reimagine access.

Sarah Owermohle 07:03

Yeah, I want to get to that, but she did put you on the spot, Dan.

Daniel Knecht 07:09

Love talking about GLP-1s. It's such an exciting time in health care, frankly. So my name is Dan Knecht. I'm chief medical officer at EmblemHealth. I'm a practicing physician, and I'm a New Yorker. EmblemHealth, for those who don't know me. It's probably—those who don't know EmblemHealth, we've been in New York City for about 90 years. We're one of the oldest not-for-profit health plans in the United States. We also have about 35 clinics across the five boroughs serving all New Yorkers of all stripes. So it's an exciting organization. But to Deb's earlier question, I think it's something interesting about GLP-1s and just—it's also an indicator that consumers and patients are looking for more choice and accessibility, and they want to consume and engage with health-care system in new and novel ways. So from a payer perspective, I—and a physician, I'm a bit worried about the increased fragmentation of this model, right? Because we have data. We know what's medically appropriate. We understand these drugs need to be prescribed in concert with a lifestyle program. We want to be good stewards of dollars. So this is a, you know, we need to be focused on the further balkanization of health care. At the same time, about 50 percent of employers don't cover GLP-1s for obesity. So that an additional avenue to getting access to these transformative drugs is really important as well.

Sarah Owermohle 08:37

AmirAli, moving to the broader conversation about access imagined or reimagined. It seems that a broad scene now is that people want more information, more of their own health care data in front of them, and then that's a message that we hear in the Make America Healthy Again movement, and kind of just the conversations happening right now. So can you go into how Guardant is a part of that, and just what the conversation looks like now.

AmirAli Talasaz 09:01

Yeah, sure, I'm AmirAli Talasaz. I'm co-CEO of Guardant Health. We are the pioneering company in the field of liquid biopsy, trying to, you know, with the mission of redefining cancer detection management through a simple, routine blood test. And maybe connected to the previous conversation about GLP-1s, I

think there is a lot of power in giving consumers the choice and making the health-care services and products accessible in an equitable way for all kinds of consumers. So the way we try to do it with our simple blood test for advanced cancer management for treatment selection—we have a simple blood test now used by over 30 percent of all advanced cancer patients in the United States—that patients get empowered to use the right treatment and clinical trial. And now the new product that we have for SHIELD—blood cancer test for first indication of colorectal cancer—is effectively bringing a very routine, simple blood test in a very accessible way to patient to get screened for colorectal cancer. It's a new choice for them, and we've been always committed to make sure that the people get accessible and equitable access to this kind of lifesaving technologies. Providing choices and providing empowerment to the patients is very key in these topics.

Sarah Owermohle 09:25

I would ask the same question, kind of in a different way to you, Dan. Just people want to have more information in front of them, more data. And you said yourself that we were seeing not just the GLP-1s, but more broadly, people want to have more choice. And how do you approach that in the space that you're in?

Daniel Knecht 10:53

Yeah we have a really unique model at Emblem Health, where we're an integrated payer. We have clinics. We provide health benefits to about two and a half million New Yorkers—Medicaid, Medicare, many union workers. And New York is such an interesting place. You have such—over 800 languages are spoken in New York. You have one in four households are immigrants. And so it is so important to meet people where they are. So we set up these neighborhood care clinics. They're actually community centers. There's 15 of them across the five boroughs. And really the intent there is to be in the community, engage anyone in the community who walks through our doors, help them navigate their health benefits, apply for support as it relates to social determinants of health. We even have Zumba and chair yoga and Tai Chi. And so really, the idea here is to build that longitudinal relationship with the community, so when they have a health concern, they come to us. They trust us, they'll listen to us. And also, I think one other important component of our clinics are that the physicians and the nurses come from those communities they serve, and that really helps deepen that trusted relationship. Because ultimately, in health care, you really can't—I love the movie Groundhog Day, but you can't have that in health care. You need to move the ball forward as it relates to improving the health of those individuals by building that trusted relationship and being there longitudinally.

Sarah Owermohle 12:23

Since you talked about sort of the on-the-ground work in New York, I want to start this question with you, but then ask other people here as well: How much did the COVID-19 pandemic change the way that you do things or teach you how to do things differently?

Daniel Knecht 12:39

Terrific question. I'll just use the use case of telehealth. During the, you know, the first wave of the COVID-19 pandemic, which impacted New York disproportionately—tough because we were at the sort of the—we were the first impacted city. Telehealth really paid off in spades. Almost everyone who could interact via telehealth did. And that saved lives, managed to prevent additional illness. But now what we've seen is sort of a right sizing of the use of telehealth. Certainly, telehealth is used more now than it was pre-COVID-19, but I think patients are voting with their feet. They're coming back into the office. They want to have that longitudinal, trusted in-person relationship when they can. However, there's one exception to that, and that's in behavioral health. The majority of behavioral health encounters continue to be with telehealth. I think that speaks to probably privacy considerations and access. So it's sort of a nuanced story, which I think can be sort of expanded to reflect what COVID-19 has done more broadly with the health-care system.

Sarah Owermohle 13:47

Neil, I'll move it to you. I'm sure Amazon has a lot—[inaudible]

Neil Lindsay 13:49

I don't think I introduced myself probably, I'm Neil Lindsay. I lead Amazon Health Services, which we have, Amazon Pharmacy, and One Medical and a few other services. But One Medical, we claim—One Medical after the pandemic—but One Medical, I think, was somewhat of a pioneer in telehealth pre-pandemic. And of course, the need for telehealth amplified during that period. I do think there is a continued you know, we have 220 offices as well for in-person care and so forth. However, the convenience of telehealth is so important, I think. Now when we think about the inputs that matter most, I think of the four Cs. We talked about choice already. Curated, informed choice, because patients deserve agency, and in many cases, in healthcare, they don't feel like they have it. Convenience, because if something's easy to do, they'll do it. And obviously in health care, to get people to be healthier, we need them to be more engaged. So telehealth is such a big contributor. And just to finish off the four Cs. Clarity of costs. People don't know what things really cost. They don't know what their out-of-pocket cost is going to be, we need to reduce that friction, so we're very much trying to invest in that effort. And then, as you mentioned, then continuity of care. Clearly there's a real risk of fragmentation with choice as—and we really see the primary care provider need to be at the center of care, and that we feed as much as possible back to that primary care provider with the help of artificial intelligence (AI) and making that less and less confusing, to ensure that the patients are getting continuity care, whether it's telehealth or in office, or, you know, even how they might interact, generally with tools.

Sarah Owermohle 15:25

I wanted to ask you, too. Amazon has ventured into healthcare before with Haven, the JP Morgan, Berkshire Hathaway venture that folded after three years. So I wanted to ask what you learned from that and what's different now.

Neil Lindsay 15:40

In all honesty, I wasn't involved in Haven at all. And the truth of it is, it's one of those questions that keeps coming up, but it's like, let it die already. You know, I think that—I don't really have a good answer to that, because I wasn't necessarily there. But I think our mission as Amazon has always been to be Earth's most customer-obsessed company. So thinking about it from a customer and consumer point of view, we try to look at—that gives us permission to go anywhere there's a bad experience, and see if we can embed on that experience. So from my perspective, our investment in health services is very much about trying to reduce friction. It's that mission I mentioned earlier. How do we make some things that should be easier, actually easier in health care? How do we make it easy to find, choose, afford, and engage with everything we need to get and stay healthy? Haven, of course, was much more on the employee benefit side of ideas and so forth. And so I'm not the—I'm not the person to answer actually.

Sarah Owermohle 16:35

Well I guess I would ask then just the whole panel—what do you think if there were another type of Haven out there in the world today. What kind of collaboration would be needed between employers and different businesses to break or change the way the health care system is now? Maybe we can start with Deb there.

Deborah Glasser 16:53

Yeah, and if I could go back to your question about the pandemic, because I think it fits. And while telehealth was obviously something that was very convenient for the time. You know, much of the pandemic is being rewritten or yet to be written about what had happened. But one of the things that I took away, and where I sit in this ecosystem, was we have never launched an innovation with so much health equity. I mean, was it perfect? No, but we got that COVID vaccine to all communities, and we innovated ways that we did it. We met communities where they were, we found new partnerships. We built new infrastructure that feeds into the system of rethinking what collaboration looks like. And I think it's a good template for how we can solve some other access problems and bringing people together across the value chain. Chris in the CMS panel yesterday made a comment, that he said when he got to CMS, one of the things he realized were that people that decide to work in healthcare are generally good people, that there's a selection bias of people who choose to make their livelihood in this and it's mission driven. And if you get enough of those people together to solve a common problem, I think you're gonna have pretty remarkable results.

Sarah Owermohle 18:06

So where do those people come from in the health-care ecosystem?

Deborah Glasser 18:11

Listen, I think it's having a payer sit down with a manufacturer and figure out ways to remove patient frictions. Having a company like Amazon who could teach us so much about that obsession with the customer experience, because there are many unnecessary frictions. In the green room, we were talking about utilization management criteria. And you know, what that does for a patient experience. My name is on the Sanofi website. I get inundated with emails and snail mail and voicemails from these—just heartbreaking stories of patients who can't access therapy because they get caught in these frictions. And I think, you know, all of us can collectively work together to—we're all for-profit companies, and we should be. But how do we, you know, put that patient back in the center and fix some of those problems.

Neil Lindsay 18:57

If I can just add that, because I don't mean to be flippant about the Haven comment. But I do think the opportunity to collaborate to reduce friction is the theme. If all of us could just reduce one small piece of friction that we know exists for our patients and customers, which we know—I think everyone in this room probably knows something in their organization that is friction that they haven't dealt with because it doesn't necessarily have a return on investment. But if we could reduce that friction, and each of us do some of that and stack those up, it'll make things simpler. And I think that's the point of collaboration between enterprises and payers and providers that's necessary to really make a difference.

Daniel Knecht 19:38

[Inaudible] Thank you. Deb had some really great points around collaborating differently. And so I just think about what we've recently done at Emblem. We had a legacy PBM, we cycled them out, and then we put together a different pharmacy model. And really the idea was to find the best capabilities and bring them together seamlessly. So essentially, what we put together is we're working with Prime Therapeutics to have transparency as it relates to drug pricing. We pulled in Judi Health for their software, the claims adjudication platform. It's in the cloud. It's API based, very flexible so our members and our customers can get a better handle on costs and benefits structure. And then excited to say we're working with Amazon Pharmacy. Right we just announced this last week. So we'll be using Amazon for same day, both acute and chronic medication delivery, because they just have world-class customer experience as it relates to pharmacy and beyond. And then finally, for specialty we're working with Free Market Health, which is a real time auction platform for specialty medications. So we can really drive competition and get the lowest cost of specialty medications for our members. So I think the era of these walled gardens is over in health care, we really need to open up the ecosystem and work differently with like-minded folks as it relates to being mission-oriented.

AmirAli Talasaz 21:10

Yeah, I want to also maybe bring the perspective of innovation here. I think we also need innovative partnership models. When you think about during last 10-20, years, the rate of innovation in the field of biological science has advanced it significantly. On the therapeutic side, or, for instance, the area that we are focused on understanding biology better, to bring better tools for cancer management early detection. Now what we need is—on innovation, the speed has gone up, but we need to figure out how to make those innovation accessible for all in an equitable way. The solution would be innovative partnerships. Manufacturer's side to the point that has been raised, health-care systems, payers, more importantly, advocacies, and also regulators. Sometimes some regulatory red tapes that we have are really reducing the speed of how fast we can bring these innovation to the patients. Maybe I just give an example. So colorectal cancer is the second leading cause of cancer-related death. And to the point about even COVID, the rate of colonoscopies and scheduling, you know, and getting access to colonoscopy was much harder. So more than 70 percent of the patients were behind on their screening. Now, in these days, there are multiple solution like blood-based cancer screening that patient can get access easily. But there are some kind of financial disincentive for some of the providers to get access to this kind of blood test and provide broadened access. I'm very pleased with some of the positive movement that we are seeing in especially the new administration that they are trying to remove some of these red tapes. But just imagine a day that rate of access to these innovation can match the rate of innovation speed that we are seeing today, the life of patient would change for better, much faster.

Sarah Owermohle 23:09

You referenced the administration trying to move some of that red tape. Could you go into that a little bit more—what the administration is doing and and how does that relate to, for instance, the CDC's Preventive Services Task Force and their work in recommending screenings.

AmirAli Talasaz 23:25

Yeah, actually, that's very interesting question. So I was actually proud that, for instance, in month of March, which is Colorectal Cancer Awareness Month, White House—President Trump celebrated American innovation of now a blood-based test for colorectal cancer screening. And the fact that now, right after our FDA approval, for instance, CMS was very pioneering and provided access to this lifesaving test for all Medicare beneficiaries. Almost all federal programs actually cover the test. But when we are going to the younger patient population, which could really use this kind of innovations much better, the access pathway for them all depends on guideline inclusion. And that's typically for like, much slower process for diagnostic versus therapeutics—that that process, sometimes for cancer screening takes up to 10 years. Federally-funded agencies that define what kind of preventative services US citizens needs to use. For instance, the last time they look at colorectal cancer was in 2021. Now what we are seeing—I'm very pleased and excited with some of the initiatives and the attention that this field is getting—that maybe we can go through those kind of processes much faster than before, and making sure these innovations, you know, can provide financial incentive for providers so that which you know, incentivize

them to use them in practice. Right? Don't generate financial disincentive, but more importantly, make sure that the young patients would get access to these kind of innovations.

Sarah Owermohle 24:58

You brought up something important earlier in your comments about equity. And, you know, maintaining that even as we deliver new forms of care. And so I wanted to put it to Dan and Neil probably first. Just as technology changes, as telehealth has shifted to—like how we maintain equity based on where someone lives or what they have access to, especially technology-wise. Maybe Dan first.

Daniel Knecht 25:34

Happy to start. Just one quick comment—I think it's really important to highlight this statistic where—you have a medical breakthrough, on average, it takes up to 17 years before that medical breakthrough is embraced and available widely across the US healthcare system. So just a tremendous lag and missed opportunity, right? And even when, when you do have mainstream adoption, to your point, there are many communities that still lag in terms of getting access to that. So, you know, the solution is—one solution, or one key ingredient is being in the communities that you wish to serve. So I think about our neighborhood care centers. We have about 100,000 New Yorkers come through our doors every year and they're looking for support as it relates to navigating benefits, do some Tai Chi, socialize. But one thing that keeps coming up is many of these members come with packaged iPhones and tablets, and they have no idea how to turn on the phone or activate the tablet, even though it's fairly easy now. There's still a lot of folks that really struggle there. So being able, spending the time up front, educating, being compassionate, culturally sensitive. These are still key ingredients to how we need to deliver health care.

Neil Lindsay 26:54

Yeah, when I think about equity, I think especially about convenience, affordability, quality. And our mission is inclusive. As you might imagine, as Amazon, we serve a very broad audience, and our health services mission is to do the same. To do that, we have to continue to expand that choice and availability and convenience. You know clearly already some things like just delivery to your door, even in a rural location helps with pharmacy deserts, virtual care, telehealth, I can see us getting more and more into more complete care by telehealth. When it's not possible to do it in person. Clearly, a lot of in-home testing and other things is going to make that more and more possible. So I think it's just continuing constantly to innovate on those fronts. You know, once upon a time, two-day delivery was considered fast. Now it's—we're talking hours. So where we're at today, and where we'll be at in the future is probably a different place. But as we continue to innovate and expand that choice and improve the convenience and improve affordability, which to some extent, we have the least control over as you know—given how things—but at least giving clarity cost and innovating on things—like we have a product called RxPass, which is a $5 subscription that gives you access, unlimited access to the generics, obviously. If you have a prescription for them, whether it's two or three or four, including the shipment, that helps with

affordability and it helps with adherence. So just continuing to innovate on each of those dimensions is the way that we think about trying to address equity.

Sarah Owermohle 28:26

Deb, I want to shift gears a bit, because you mentioned when talking about the pandemic earlier, that of course, it was remarkable the speed with which vaccines were developed and then distributed. There's a lot of people who don't feel that that was a remarkable achievement, and the climate around vaccines right now is that there's a lot of distrust, and there's a lot of distrust of pharmaceutical companies. And so you are vaccine makers too—how do you approach this current moment?

Deborah Glasser 28:54

So I actually used to run our vaccines division at Sanofi, so it's an area that I'm quite passionate about and increasingly worried when science is often—when you lose that level of trust in public health. And sort of my knee-jerk reaction that I had someone share with me once that now I repeat, is the question of, did you wake up this morning and brush your teeth? And most people say "yes" they did. And did you use tap water when you turned on the sink? Yes, I did. You trust public health. You know, we're in—we've made incredible investments. And to carry on the theme of water, you know, after clean drinking water, the most cost-effective intervention in public health will always be vaccines. I think the story of how we came together to develop that vaccine is remarkable. And I think the president deserves a lot of credit for what was done. Were there mistakes? Absolutely, and I think that's the history that still needs to be written. But what I don't think we should take any shame in is how we collectively got together and built these new partnerships. You know, when I took over Vaccines, I met all these groups. I'll give you an example, the Worldwide Boxing Association. I know nothing about boxing, but apparently, incredibly multi-generational and very strong in Hispanic and African-American communities. They did enormous outreach to figure out how to provide the COVID-19 vaccine, and afterwards, influenza vaccines and other seasonal respiratory vaccines. So those partnerships are incredible. You know, where this trust is around vaccines—I think we need to do a better job of telling the story about how far we've come and how far we can still do within prevention. And I actually think it's part of—at the heart of what is the MAHA movement—about keeping people safe, hitting disease before it's a large, expensive health care problem.

Sarah Owermohle 30:56

No, that's a good point. I mean, a big part of the MAHA movement, of course, is that we need to end chronic disease. We need to end these problems, like you said, before they become health care ailments. And you, as you said, Sanofi has been in diabetes for a very long time as well. What kind of conversations have you had with the administration about what role you can play. Because we know Secretary Kennedy, for instance, isn't a very big fan of pharmaceutical companies. Let's put it that way.

Deborah Glasser 31:24

So one of the things we announced in terms of our diabetes is our value program, which any American now for $35 can have access to any insulins they need in any combination of what they need, which certainly puts insulins in the reach of any American that needs it. We have doubled down on our commitment to insulins. A lot of manufacturers are backing out of that space, but Sanofi plans to be there for the long term.

Sarah Owermohle 31:53

Have you had any conversations with the administration about TrumpRx?

Deborah Glasser 31:53

So we publicly said that we're in conversations with the administration. We were one of the 17 companies that received a letter on July 31 and there are some of our products that would make sense on a TrumpRx.

Sarah Owermohle 32:12

I wanted to also, well actually, I am going to shift gears again. Because one thing I noticed from some of the prep call conversation is that in some form, each person talked about artificial intelligence. It obviously is a big discussion in everything right now, but especially healthcare. And so maybe starting with Neil, just how—how are you thinking of artificial intelligence as part of your space and and how far is too far? Maybe with, with using AI and health care?

Neil Lindsay 32:41

Did you say how much is too far? So, you know, clearly, Amazon's very heavily invested in AI, and we think it's super important in healthcare to, especially, first and foremost, to make the providers' lives easier. You know, we have a shortage of providers. Providers are generally overwhelmed. You know, the digitization of healthcare means that patients can communicate more and more with providers, which, frankly, just means they get more and more after hours tasks to deal with. And a lot of those tasks, frankly, could be dealt with by AI. They're questions that an AI could answer very safely and appropriately that might take it off the list of a provider to have to deal with. There's, you know, obviously ambient listening is something we've invested in as AWS, and that we use in more medical tools to help reply to communications, that help draft those communications. Importantly, I think it's really important for us to use AI to extract insights from health records so that providers can quickly focus on the pertinent conversation they need to have with the patient. I get very, very excited about that aspect. As you think about all of the information that is becoming available, that's really necessary, and we all know that's a burden for providerset. Gets particularly interesting, I think also when we start thinking about that front door, the

access that the patient might—how patients might now access health care. You know, clearly there's a lot of opportunity has to be—we have to approach it, you know, as fast as possible and as slow as necessary to make sure it's safe and governed, and all those sorts of things and medically appropriate. But you can imagine, it's already happening. How many of you asked your ChatGPT, or some other AI a medical question you might have once before asked your provider. So that front door is already happening, and those conversations gather a lot of information that can be very valuable in a provider conversation. So we need to be able to, you know, obviously, with privacy—respecting privacy and doing it with permission and so forth—use those tools to help understand what a patient's need really is. And perhaps, in some cases, maybe not necessarily have it go to a provider— if actually the you know, the stubbed toe doesn't always need a primary care appointment, right? So I think there's a lot of opportunity for AI to certainly help at the back end, certainly help the providers in making their roles more sustainable. And I think there's a lot of interesting opportunity in the front end to achieve efficiency in a way that is still safe and helpful and provide frankly informed choice and agency to patients while actually improving quality and efficiency at the same time.

Daniel Knecht 35:23

I can piggyback. You had a lot of great points, Neil. I'll start off by saying, what is too far? I think that was what's too far with AI—certainly denial of care. Health plans will not deny care using AI, right? That's the full stop. But I think AI is a force multiplier for a health plan. So an example would be this summer, we launched a program to alert our most vulnerable members to an incoming heat wave. So heat waves are, unfortunately, the silent killer as it relates to natural disasters. Each year, about 500 New Yorkers die from heat waves, and those are some of the most vulnerable folks—elderly individuals with chronic conditions or pregnant women. And so when we launched an agent, it was an AI agent that would do outbound calls to our vulnerable members. About 50,000 New Yorkers received phone calls from us and engaged with this very lifelike nurse. Her name is Rachel, just AI. On average of about five minute conversation. Rachel talked about the incoming heat wave, talked about cooling centers, talked about some specific actions that individual can take to stay safe as it relates to this incoming heat wave. Rachel even talked about pet safety. So this is something we could not do without AI. We only have a certain number of care managers that can make outbound calls, so the ability to scale impact very quickly using agentic AI was a great use case. So more to come on that we're actually going to be doing flu vaccination outreach with Rachel in the coming weeks as well, hopefully

Deborah Glasser 37:00

Hopefully with Sanofi flu shots—

Daniel Knecht 37:01

Abolutely. So I'm very bullish about AI, but you need to keep a human in the loop. You need to really build AI around the member in a really thoughtful way.

Sarah Owermohle 37:12

Do people generally have a positive view of Rachel the AI nurse? Because I feel like sometimes, especially older people, don't want to talk to AI as a nurse especially.

Daniel Knecht 37:22

Well yeah, it was surprisingly quite the contrary. Older folks, our MA population, love to have a conversation with Rachel. She was infinitely patient and kind and empathetic, really positive feedback. But probably the most interesting part I listened to a lot of these calls was—we called a patient in Spanish Harlem and Rachel called and said 'Hi, this is Rachel,' and then the patient responded in Spanish. And Rachel, she's bilingual. Incredible how quickly she just switched languages. So really capabilities even a human couldn't do in that regard.

Sarah Owermohle 37:54

That's really interesting. Oh, you looked like you wanted to say something AmirAli, but I was going to come to you anyway, on another technology question. Well, I wanted to tack on to this, as we haven't talked yet about just digital tracking apps or, you know, wearables, that's a big thing right now. And I wanted to ask, especially you and Deb, just like kind of how you think about those things and incorporating them in the business that you do.

AmirAli Talasaz 38:19

So maybe I can tell you actually a little bit about how you're using AI in biological science and connected to this kind of chat functions. So it's very amazing when you're thinking about what you could discover using AI with the power of AI and high quality data and advanced biological understanding—biological science. It's kind of mind-blowing that you have less than a centimeter tumor in colon or lung or somewhere else. And if we did like blood tests, you want to detect it. All that has been powered by the fact that we captured very deep genomic, epigenomic data in over 1 million patients correlated with their clinical data, and then figure out, what are those signatures associated with cancer versus some other kind of findings in the blood sample. And that was powered with the advancements in AI and data analysis technology, which is out there. So that's the way that we were really the beneficiary, and we meet this kind of breakthrough, pioneering technology. And now connecting it to the chat function. It's very interesting, like the biology is becoming more advanced and complicated to a sense that even it's hard for physician to understand, forget even the patients. So what we've seen, really in practice that's helping is AI-assisted interpretation of some of our clinical results for physicians and AI-assisted conversations with the patients that we are just piloting in terms of helping them navigating through the datas that we report to them so they can actually be empowered in terms of what they're going to do in this cancer journey. So we are very excited with those kind of elements, but all those, I think the power of AI would be just limited to the high quality

data and the extent of data that you're going to feed into those kind of learning models. We've been fortunate that, throughout many years, we captured like over 1 million cases now that we are utilizing.

Sarah Owermohle 40:18

Deb, can I ask you the same and tack on just where wearables and digital health tracking apps play a role.

Deborah Glasser 40:23

So I've been at Sanofi for about three and a half years. And I think Sanofi, of sort of the manufacturers, has been the most holistic in our approach to digital and AI. Most of what's been achieved has been in RD and manufacturing, but we're just now getting into that sort of big C—commercialization. And I think wearables are fascinating because it's building a new data pipe into the health system. You know, you can go buy wearables now that will have the MyChart app on the box. And, you know, that's like inning one of a patient being able to collect their own data. Amy Gleason in the panel that closed yesterday said, we're a year away from having a personal Rachel, that's her name, right? Rachel. Taking care of us and answering all of our health questions. So all of these are building new data pipes that, as a manufacturer, I have to think about how that I can help them be in service of that, and I think it's part of this connective ecosystem about what is my role as a drug developer? How do I work with a payer? How do I work with interesting partners, with diagnostic companies to really help that patient maybe find disease earlier. Have a conversation that they're afraid to have when they get that eight minutes in front of a doctor who's got their face in the EHR. And those are all things that we're talking about in this next step, but we're clearly at this hinge moment where, you know, everything that made me successful over the last two decades is quickly sort of going away, and how do I participate? And I think wearables are just the first chapter of that.

Sarah Owermohle 40:24

We are nearly at time. So I'm going to ask a lightning round question, a really easy one. Since we're in Washington, if you could each wave a wand and make a policy change, or at least just have us start talking about a policy that you want, what would it be? And I'll start with you, AmirAli.

AmirAli Talasaz 40:24

I would ask the White House or HHS or CMS to put a directive and add blood-based cancer screening, colorectal cancer screening as a quality measure for payers and providers.

Neil Lindsay 40:24

Transparency. This clarity of cost topic is a really important one. I think we need consumers, patients to know what things are going to cost, and they need to know it up front. I think policy would help.

Daniel Knecht 42:48

I'd say conceptually, afford more flexibility to pay for more services and goods that are not considered medical care. So I think about food-as-medicine, paying for exercise. The vast majority of these chronic conditions are all secondary to lifestyle problems. So how do we incentivize lifestyle changes? Pay for healthy food, pay for exercise. That's what I would push for.

Deborah Glasser 43:12

I'm very conscious of who's coming on the stage after us. And if I had one wish, it would be, you know, we're at this moment where there's a future where computational biology can be computational medicine. And if we could rethink about how we approve drugs, that we could truly match the richness of biology with an intervention. And I think that would solve a lot of the access issues. Because I wouldn't be in conversations or sometimes fights about TAs and utilization management, if we could better match the biology with the intervention.

Sarah Owermohle 43:46

Interesting, as you reference the people coming on stage next. I think I've talked in some capacity about each of these things, so hopefully we'll talk about them soon. But thank you all so much for being on stage today.