COMMUNITY ACCESS, INFRASTRUCTURE, AND INNOVATIVE CARE DELIVERY

Announcer 00:00

Please welcome the panel to the stage.

Bertha Coombs 00:15

As we like to say in television, "And we're back." So, let me introduce our panelists in this session. On the end is Chuck Henderson. He's the CEO of the American Diabetes Association. Next to him is Shantanu Agrawal. He's the Elevance Health chief health officer. And next to me is Steve Anderson. He's the CEO of the National Association of Chain Drug Stores. So, we talked about how we now are using digital platforms to help people manage these metabolic diseases and, in some cases, also give them overall care, which oftentimes people don't have time when they go to their doctor. But you guys are talking about how do we bring this into the community, because I like digital care, but in-person care sometimes is important. You need to talk to an actual person, look them in the eye. And how do we bring that into a community and make it accessible at a time when there are so many cutbacks, and particularly in underserved communities where people may not have access to the drugs, and yet they suffer from a lot of these diseases? So, Chuck, I want to start with you. You started the 2024 Obesity Association because you said we have to go upstream on these big risk factors for type 2 diabetes.

Charles "Chuck" Henderson 01:41

Yeah, when I think about—and obviously, thank you for being here and I'm a big fan of yours, Bertha, and so, thank you to some team that I have in here sprinkling. But look, we launched the Obesity Association, which is a division under the American Diabetes Association in 2024 to address those issues that you're talking about. When you think about tackling type 2 diabetes, one of the leading risk factors is obesity, right? And then when you think about stigma, right? We want to encourage people to go into the doctor. So, we want to work on the stigma. And then the third thing is we want to reduce the barriers to care. And I think the most important thing is that we have our standards of care and we're on chapter four right now, and it's just not about the standards. It's about taking those standards and putting those standards into practice. And so, to your point about the community, we have some great community partners in this room. We're actually going into the community. We have relationships with providers, with health

systems, with community-based partners that have the trust of the community, so we can get them into care immediately. But the biggest thing for me is education, right? People still don't understand how great these GLP-1s are. I literally think that in 30, 40 years, you're going to see tremendous health outcomes because of all the other things that these GLP-1s help with.

Bertha Coombs 03:04

If people continue on them and have access to continue.

Charles "Chuck" Henderson 03:07

If they have access. And access, that's the million-dollar buzzword. You've got to have access. And we need to work together—public-private partnerships—to invest, to get the access, right? Because when I think about commercial pay, 30 percent. What about the other 70 percent that don't have insurance, that are underinsured? What do we do about that population?

Bertha Coombs 03:29

Which is one of the things that was interesting. I posted about this on LinkedIn, and one of the comments I got is lowering the price is meaningful, but it doesn't necessarily translate into actual patient access. And Shantanu, you're with one of the large health payers, health insurers, and one of your competitors no longer covers it for its own employees, which to me was incredible, considering that they have a sizable PBM. So, you would think they would be able to get it at a pretty good price. How do you manage access in your plans? And is it easier in government plans? Is it easier with employers?

Shantanu Agrawal 04:13

Yeah, it's a great question. First, thank you for the opportunity to be here. For those who may not know Elevance Health, you may recognize our insurance brands, which are Wellpoint and Anthem. So, we insure 40-plus million Americans across Medicaid, Medicare, the ACA individual marketplace, and, critically, employer-sponsored insurance as well. So, I think access really is important. When I think about GLP-1s, certainly from a health standpoint, they clearly play an important role in the management of cardio diabetes—of cardiometabolic conditions. But I do think that they need to be part of an overall system of management that sort of supplements pharmaceutical options with other options that meet members where they are, right? Members obviously have vastly different social needs. They are living in communities with vastly different resources. We see that throughout our network. And they are part of organizations that have very different benefit design. And so, what we really try to encourage is access to the GLP-1 wherever that is feasible. And to answer your question, there's a lot of state and federal policy that we necessarily have to follow around this. Most Medicaid programs still do not cover GLP-1 access, for example, just for the treatment of obesity, but they do cover it for the treatment of diabetes. So, there's a lot of requirements and policies that we must navigate in order to work in those programs. And then similarly, with our employer-sponsored insurance, the employer really does get to decide. And to me, this comes back to a few things that I know we'll get to focus on a little bit. One is, what is the system of care that you're really wrapping around a member so that the GLP-1 is meaningful and inside a broader context where you're thinking about food and nutrition access and other changes? Number two, what is the adherence? How are we going to address the adherence issue? You kind of pointed at this. When you look at different member segments, we find that members—30, sometimes a third, and sometimes as much as two-thirds of that member segment—will actually stop taking a GLP-1 within the year, right? For a host

of reasons. Cost, I'm sure, is one of them, but so are the side effects and other issues. So, that adherence issue is, I think, a real challenge for this area, which leads to the third area that I think we have to solve for is how do you make sure that this pharmaceutical intervention is going to drive outcomes? Is it going to address the diseases for which you're taking it for? Is it going to help with weight loss? And is that going to be visible at a time that makes sense for the premium payer, whether it's an employer or a public program?

Bertha Coombs 06:50

How does that adherence percentage compare with other drugs?

Shantanu Agrawal 06:56

That's a great question. I think 20 percent to 30 percent, let's call it, drop-off rate is something that I see more consistently with other medications. Look, adherence is an issue throughout health care, right? I'm an ER doc. When you think about core medications that are proven, there's a set of medications that get prescribed if you've had a heart attack. This is for people who've had the heart attack, right? They've had the bad outcome. And they're typically prescribed at least five different drugs from different drug classes in order to prevent the next heart attack. The adherence around—they're having a good time over there—

[Laughter from adjacent session]

Bertha Coombs 07:33

It's not funny.

Shantanu Agrawal 07:34

Point that out. We've got a serious topic going on here. I'm kidding.

Bertha Coombs 07:40

I guess they're waiting for the punchline.

Shantanu Agrawal 07:42

Yeah. The adherence, even in that situation, is not what you would expect. It is not 100 percent. It is more like 70 percent to 80 percent, and we're seeing similar adherence issues for GLP-1. So, I think the two-thirds drop-off, that's very, very high. But certainly, there's going to be adherence challenges no matter what.

Charles "Chuck" Henderson 08:00

Can I add something, Bertha? I'm sorry, but when I think about the cost of not doing it—and so, when I think about it from an advocacy standpoint, especially at the state level, we have a cost calculator that says, "Okay, if you don't do it, this is what it's going to cost you, and if you don't do it"—right? And not to pivot, but when I think about the health-care system, what's the cost of not doing it? And we've got to get people healthier.

Bertha Coombs 08:30

The cost of not treating someone with diabetes—yeah—and them ending up with a leg being amputated and then not being able to work.

Charles "Chuck" Henderson 08:37

Yes.

Bertha Coombs 08:38

What's the cost of that?

Charles "Chuck" Henderson 08:38

Financial health equals—right. Yeah.

Steven Anderson 08:43

And I'm here for an answer.

Bertha Coombs 08:46

Okay.

Steven Anderson 08:46

I can answer all those questions. Just so you know, I'm CEO of the National Association of Chain Drug Stores. So, we represent drugstores, all the grocery stores, and then the mass merchants, all with pharmacies. And we decided we were going to play a major role in COVID when it happened, and 90 percent of all Americans live within five miles of a retail pharmacy. Our members—retail pharmacy—gave 340 million COVID shots during the pandemic. That is more than 52 percent of that—

[Crosstalk]

Steven Anderson 09:19

—and I'd ask your audience how many got a shot in one of those venues but I'd probably violate some kind of HIPAA law if I did that. But when we came out of it—

Bertha Coombs 09:27

But if they want to—

Steven Anderson 09:28

—I worked with our board of directors. What's the next big public health crisis? We could do it. Because we could see how we could move with scale and speed really, really quickly. We could do 100 million shots in 30 days, which really basically got the country out of the pandemic. So, we settled on chronic disease, cardiovascular disease, diabetes, cancer, and neurodegenerative diseases. And we've had a great partnership throughout this whole thing with Milken. We did a report on—

Bertha Coombs 09:57

I was going to ask you about that, in fact.

Steven Anderson 09:58

We did a report. I looked at your notes. We did a report on *Food Is Medicine*, which is part of this equation. GLP-1s. We did one on expanded pharmacy services. And the trifecta is the culmination of the report we issued today on GLP-1s. And that it has to move beyond the prescription. It's absolutely important, and it's very well outlined in this report, and I'd have everybody really read it if you wanted to really understand government policies towards GLP-1s. But if you look at why people discontinue the use and nonadherence, it's cost, right? And side effects. Side effects were like, it was some staggering number. 80 percent of the people have certain side effects. But there's also questions of basically administering the GLP-1s. There's nobody at home to help them.

Bertha Coombs 10:51

They should have done this as Part B.

Steven Anderson 10:54

Well—

Bertha Coombs 10:55

Except people couldn't get to a doctor necessarily, but if you went to your pharmacist and got that shot, then it's covered under medical, right? But not under your—

Steven Anderson 11:02

But it's administration, it's adherence, it's side effects, it's dosage. We have people trying to determine their own dosage. It's affordability. The pharmacy. Pharmacies were the heroes in the implementation of Part D because they navigated the health-care system to help those people that were impacted. So—

Bertha Coombs 11:22

And you want to have the pharmacies more at the center of this. But I've got to tell you—so, as a caregiver for my mom, there was an independent pharmacy that was near her senior center. Those people were amazing.

Steven Anderson 11:34

They are great.

Bertha Coombs 11:34

They helped me navigate all of the systems. It was really great. I go to my chain pharmacy on the corner, and I have to say, I feel for those people. They have so much to do. When we line up for our vaccines—there was one day it was just the line was so long, and the pharmacist still had to dispense medications and still sort through the payer, whether or not this was covered and where you were in your whole process of

your deductible and all of that. So, I love the idea of the pharmacist being at the center, but they are doing so much already.

Steven Anderson 12:15

Well, because it's the structure of how the system is set up that needs ultimately to change. Our members include companies with four stores up to very large chains. And part of the issue is that—and we need this with GLP-1s—is to set up an infrastructure so pharmacy can do this in different areas beyond probably what you're seeing right now, probably based on your experience. But pharmacists have informally been providing counseling advice on GLP-1s. But we need an infrastructure that is structured and highly sustainable so they can do this. Very bizarrely, under the Social Security Act, pharmacists aren't considered health-care providers. Other people are, that might surprise you—

Bertha Coombs 13:07

So, it's taken—

Steven Anderson 13:08

But why not pharmacies? Where we got—

Bertha Coombs 13:09

It took the H1N1 first, and then the COVID for us to realize, "Wait a minute, these guys are a part of it."

Steven Anderson 13:11

Yeah. When I got here, we couldn't even immunize, right?

Shantanu Agrawal 13:17

Just to chime in on that point—and I know you had the digital conversation right before this—I do think it's really interesting that we have a state, Utah, that's actually allowing an AI to primarily prescribe medications for the treatment of acne. Now, it's a really focused reason, and it's a really small set of medications, but it is really interesting to me that we have allowed for that pilot to happen before we have expanded the ability of allied health professionals to do more. I do think—and yet I know pharmacies are very busy places—but those are very trained professionals.

Bertha Coombs 13:47

I think that's an applause line. Pause for the applause.

Shantanu Agrawal 13:52

And I think we have to question—there's clearly a role that digital must and can play. It does provide access. It does expand the reach, your ability to get to people. But I question digital-only. I think digital-first is perhaps fine. And I really question this sort of "let's pivot to AI and push it in front" without taking advantage of all the resources that already exist in the system.

Charles "Chuck" Henderson 14:18

Yeah. And I just want to piggyback on what those two gentlemen said. When I think about people, people, people, there's still relationships, right? You can't Zoom and Teams. I hate those. But in terms of just being in the room, people can feel if you really care about them. And growing up—inner-city Houston, Texas—every time my grandmother, my mom, and I used to walk into a pharmacy, "Hey, Ms. Henderson. Hey, Ms. Juanita." They had conversations with you. And I know times have changed. People are busy. But I do think that we need to get back to the business of people in relationships, because that's where we feel valued. And I think that we would feel better about ourselves, about asking for care, if we had more people in those stores.

Steven Anderson 15:05

People with chronic diseases in this country see their pharmacist twice as much as their physician. It's probably 12 times—some all the time, every day. And you come out of school with a pharmacy doctorate, you're a PharmD, you're an expert in this beyond just putting pills in bottles. But the way this ecosystem is structured, they're not allowed to practice at the top of their license and their education. They're the most under—

Bertha Coombs 15:32

But that's been changing, hasn't it?

Steven Anderson 15:33

We're working on it. Yeah, we've been working on that.

Bertha Coombs 15:35

Especially after COVID, where we realized this is an underutilized resource of people.

Steven Anderson 15:41

But it took us a long time to convince people to do that. And so, yeah. So, that speed and scale, and we can determine where all those issues you raised. Digital, direct to consumer, where a lot of people are getting this product from. You need that advice and guidance because if you look at the report, it's so fragmented in terms of how the current GLP-1 distribution and therapies is being structured—

Bertha Coombs 16:07

But that's part of the other thing that—

Steven Anderson 16:09

And that's what we need to change. We need to find a payment mechanism. Pharmacy has been giving away their services for years. And there's no payment mechanism for them to be reimbursed for it. We need a structure that shows the value the pharmacy brings, which we can show that easily. But we need a set of services that are going to be based on that. And there's short-term things we can do now, but there's long-term things that we can also do in terms of—set up that infrastructure so people can—we all agree GLP-1s are fundamentally changing how chronic disease is being managed right now.

Bertha Coombs 16:50

But the infrastructure overall doesn't exist in the sense of, if you're a caregiver, you're the one that is connecting with everyone. I used to call myself my mom's chief resident. To say, "No, no, her dosage is now lower than that. I can't change it in my chart because it's an official chart. But that's now old." You have to change the titration in that. If we get the pharmacist—which is great—but how do you close the loop so that it's with the person's physician—or whatever caregiver, whether it's a nurse practitioner or something—so that there is a closed loops that everybody knows, and we can all see the progress, we can all see the adherence, and they hear from these people? So, it's not just, "Oh, I talked to the pharmacist," but your doctor doesn't know that, or your doctor talked to you, but the pharmacist only gets the script from the doctor.

Steven Anderson 17:44

You're right. There's no data sharing. Interoperability is crucial for all this.

Charles "Chuck" Henderson 17:48

That's what I was—

Steven Anderson 17:49

If we are going to solve the health-care crisis, we got to have every health-care provider, everybody in the system—

Charles "Chuck" Henderson 17:53

Sharing the information—

Steven Anderson 17:55

—have the data.

Charles "Chuck" Henderson 17:56

And when we talk about technology, when we talk about AI, let's use it for good. Let's use it for governance. I wish I could go back to when I was born in 1971 and get all of my records, but they're in so many disparate areas. As smart as people are, as far as technology is, I know that there's a way to aggregate all that information, and then you can start predicting health outcomes. And you can start getting that earlier. So, yeah.

Bertha Coombs 18:22

I know. That, for me, it's like when you were—since you were in the 1900s as well. Remember you'd get, like, "This is going to go on your permanent record."

Charles "Chuck" Henderson 18:30

TMI.

Bertha Coombs 18:32

"This is going to go on your permanent record." That's what I want from—I want a health-care permanent record. That would track you from birth to the end of your days. So, that people can find the patterns, so that people can see if there is some sort of genetic thing in your family, they're able to follow it, they're able to know it. You're with one of the biggest health-care companies. Are you guys able to create more of these closed loops that really work? I know value-based care is something that we talked about, but I don't know just how much it's really working and whether it really pays off, particularly for providers.

Shantanu Agrawal 19:14

I totally agree with the comments around wanting better data integration and better data flow. That's certainly advantageous for everybody. We spend a lot of money on trying to do that. When you think about the big data silos, we sit on a lot of claims data. We get a lot of information from services that are offered. Obviously, we utilize that data. And then there's a whole tranche of data sitting in the medical record that we have very little insight into. And so, we have poured resources into this area over the last few years, working with some of the biggest EHR providers in order to try to get access to that medical record data so that we can do the predictive work and other things that are required of us. It is really to our advantage. Let me come back to cardiometabolic for a second, but we are highly incentivized to address these issues. There is the cost of care. There's health-care affordability. Our customers, whether they're public or private, absolutely expect us to make progress on those factors. That's already an incentive. And then these programs, I can tell you from the work that I do literally every day, are highly embedded. These issues are highly embedded in quality programs. And there are a lot of quality dollars that flow with those measures. So, we are assessed on how well our members are having their blood pressure managed, on how well they're having their diabetes managed.

Bertha Coombs 20:34

That's in Medicare.

Shantanu Agrawal 20:34

Medicare, Medicaid, commercial, it really touches all lines of business. Now, the financial incentives tied to those things change according to who the premium payer is. The Medicare Stars program—it looks at those measures. Those are triple-weighted measures—

Bertha Coombs 20:49

Your fate is in those stars.

Shantanu Agrawal 20:51

Those are triple-weighted measures, and there's a lot of consequences for us. But there are a number of states that have also tied financial performance to specifically hypertension and diabetes and expect us to perform well on those. What I want people to know is these conditions in particular, we have very specific incentive structures around, and therefore, we have lots of programs to try to meet members where they are and get them the services that they need, whether that's through a PCP, through a value-based provider. All of our value-based contracts have these measures embedded in them. Or it could be care in

the home, or care virtually, care digitally. We try to use lots of different avenues because of how much emphasis there is on hypertension, diabetes, and related conditions.

Bertha Coombs 21:40

For some reason, someone who's creating laughter is always while you're speaking. I don't know what the timing is. It just seems to keep happening. I wonder about making sure that that moves forward and people follow through. Kara Egan spoke on the main stage earlier about how, with Teal, they make sure people follow through. And Midi makes sure people follow through with that next appointment, so that if you do get an assessment that, hey, there's something weird here, you have to do the next one, which a lot of people never follow through, and sometimes that can be the difference between catching something early or too late.

Shantanu Agrawal 22:22

We feel the exact same imperative. So, at the start of every year, everything zeroes out, and we're back to 0 percent performance on all of these measures, and we are literally trying to get as close to 100 percent as possible. Because that's what high level—

[Laughter in adjacent session]

Shantanu Agrawal 22:34

You're right. Literally every time. Every time. Literally every time. That is the expectation.

Steven Anderson 22:40

Can I get that laugh track and that applause track at mine?

Shantanu Agrawal 22:45

So, we want people to go into their PCP, and we do check on whether or not that occurred. We want the value-based provider to be reaching out to the member because they're incentivized to do that, and we check to make sure that has happened. We are tracking the data on literally a daily basis to try to close those loops. If we get data from a member, we pass it off to their PCP or their value-based provider because we don't want a lot of repetitive testing either. That's not good for the system. I'll give you just one example. Again, I think it goes back to structures have to match members' needs. So, we know—particularly in Medicare Advantage—we offer to basically any member that they can get these services in the home. And we will send somebody into the home to look at their quality care gaps and to work to close those gaps. And what we have found in the data—

Bertha Coombs 23:34

But are they really looking at that? Because I remember when my mom would get them, the nurse who came knew nothing about her. She checked the boxes, and it was just like, "Yeah, just give us the Walmart $15 gift card." This is nothing.

Shantanu Agrawal 23:46

I can tell you, we make hundreds of thousands of calls, and just this year, over 60,000 members have said,

"Okay, sure. Come to my home." They are specifically evaluated for their care gaps. I am not talking risk adjustment or anything else. This is for their quality of care. In those home visits, we've been able to close 130,000-plus care gaps, and a third of those are specifically cardiometabolic. Again, going back to the quality measures. So, we do offer members the opportunity. Many of them want to go to their PCP. That totally makes sense. Again, you should have the choice. Go to wherever makes the most sense for you. What I find in the data is our duals members, those with complex care needs, are the ones more likely to welcome people into their home because—

Bertha Coombs 24:31

They've gotten used to it—

Shantanu Agrawal 24:31

—it's easier access, it's harder to get to the doctor's office. It's just an easier experience for them, and so they're happy to do it. We get that data from whoever went to the home, and then we provide it to their doctor. We try to close the loop. But this is what's really important, I think, in order to try to get these needs met for the member that needs them.

Steven Anderson 24:52

So, the theme of this is community access, it's infrastructure, and it's innovative care. Those follow-up opportunities happen in pharmacy, and especially with Part D patients who are seniors, see their pharmacists, they trust them. Bizarrely, though, you can get tested for certain chronic diseases until you reach the age of 65.

Bertha Coombs 25:23

Really?

Steven Anderson 25:23

Because Medicare Part D doesn't allow test and treat for chronic diseases. So, when I said there—what we can do on the short term to fix this, you can pass the Main Street Pharmacy Access bill that's now pending in Congress, and we're trying to thread the needle to get it through in this lame-duck session that's coming through in one of the must-pass pieces of legislations. But at least it allows you to test for some of these chronic conditions. And particularly, it has to be authorized by the state for the pharmacist to do this, but we're ready to go. And once again, it's underutilized. It's right there. We don't have to build anything. It's right there. We just have to build a payment system.

Bertha Coombs 26:07

What's causing the friction? Is it doctors not wanting—although, every doctor I know is just so overwhelmed.

Steven Anderson 26:15

Some have said that. Yeah, it's—we're pretty fragmented. And the pie is only so big in health care, and everybody's fighting for that piece of the pie. It just doesn't make sense.

Bertha Coombs 26:29

I don't know. It's a bigger piece of the pie of the economy every day. And Calley Means had said earlier, one of the things that I always look at and say it's like, the biggest employers are often the hospitals, right? And so, you want to go after them, but at the same time, they are the ones who have been keeping the economy afloat in terms of job growth for the last 10 years.

Charles "Chuck" Henderson 26:57

And I know collaboration is an overused term, but we need to be more collaborative. I'm always big on collaboration. So, when you talk about pharmacy, when you talk about PCPs, when you talk about nurse practitioners, when you talk about, like—there needs to be an expanded scope of duties, at least in my humble opinion, because I'm not a clinician, and I'm not a doctor. But you talked about the piece of the pie. Why does it have to be about the piece of the pie? Because it should be about the patients, right? The patients. Everything that we should do in this room should be about putting the patients first. And I know bureaucracy, I know those kinds of things, but we really need to step outside of ourselves, especially in this interesting moment, in these interesting times, and really figure out how we can really work together for transformational impact and outcome.

Bertha Coombs 27:51

If we don't meet this moment, the rate of cardiometabolic issues in this country is just amazing. Do we need that moment where we see, "Oh, things have started to drop off because we're using GLP-1s"? Is that going to get people more interested in really bringing it down to the community level where the need is so great?

Shantanu Agrawal 28:20

This is not to move away from the importance of GLP-1s. I want to hit on a point, though, that you mentioned early on, which is this comes back to food as well, right? And when you think about community health, you think about the rate of cardiometabolic disease in our country, it comes back to issues that are very deeply rooted, that are cultural, that are societal, and I do think—I personally believe that food plays an incredibly important role. It's why—

Bertha Coombs 28:44

You mean like the cheapest food being a fried chicken provider that gives you—

Shantanu Agrawal 28:47

And the processed food, the fast food—

Bertha Coombs 28:49

—food for four people that delivers heart disease to you for only $20?

Shantanu Agrawal 28:53

Absolutely. And I understand that people in circumstances must make those choices, unfortunately, which is why we need to address the food supply chain and actually make healthier options cheaper. It is actually

something that I deeply hope HHS continues to focus on and deliver on. It's something that has very much resonated for me as this administration has come in.

Bertha Coombs 29:17

Are those Food Is Medicine programs still being supported? Because we're seeing the SNAP cuts, we're seeing the Medicaid cuts.

Steven Anderson 29:27

As I said, we represent drugstores—

Bertha Coombs 29:29

And grocery stores—

Steven Anderson 29:30

—and grocery stores. And part of that evaluation and consultation that you would have at your pharmacies, and according to the Milken report, would be referrals. We have dietitians in our stores that work closely and can work even more closely. Referrals for lifestyle changes. There's data in the report talking about the number of people who want to meet with somebody, like a personal trainer or somebody, or somebody at least tell them how they can do this. Medically tailored meals, food prescriptions are all part of this equation, and pharmacy can play that role throughout.

Shantanu Agrawal 30:08

I think that's right. I think the data is clearly there. We have seen good effects in the commercial populations, in Medicaid and Medicare. There's lots of different interventions now between nutrition education, produce prescribing, medically tailored groceries, medically tailored meals. You can think about implementing them in benefit design. There's a multitude of approaches, but I will say this: there is no private sector replacement for strong public benefits. When SNAP is reduced, that is a problem. That is just an issue, and we can't, and other companies can't make up for that. However, I do think because food is such an important intervention, we're putting real resources into creating programs around food. We are working with a multitude of partners. To your point about collaboration, this is absolutely right. This is where the community needs to be involved. But I think it's an important step because we have to stop the development of these conditions, not only want to treat them after the fact.

Bertha Coombs 31:03

Chuck, what are you most hopeful about? Because there was a time when we talked about obesity and it was just a personal failure, essentially.

Charles "Chuck" Henderson 31:13

A behavioral issue.

Bertha Coombs 31:17

Are you hopeful that we have turned the corner on that and we're looking at it differently?

Charles "Chuck" Henderson 31:22

I'm hopeful, but I'm not. Because to your point, there's some societal issues, some economic issues that I think prevent this from happening. But I'm hopeful in a way because if we could tackle the obesity issue in this country—and people talk about the US deficit, and I did some back-of-the-napkin math before I got here—we could literally take $1 trillion out of the US deficit if we really focus. But it's not just about the GLP-1s. It's just not about obesity. It's about nutrition. It's about the wraparound care. It's about ensuring, again—when I brought up earlier about the 30 percent, we're talking about 30 percent, right? What about the other 70 percent that's costing this country trillions and trillions of dollars a year? So—

Steven Anderson 32:14

In this country, we have our incentives wrong. We spend more on health care than anybody in the world, and we have the worst outcomes. You hear that all the time. Here, we have this wonderful opportunity with GLP-1s that will solve—it's fundamental to all the treatment for all the things we're talking about. And the biggest parts, you talk about those four chronic diseases, even neurodegenerative disease is based on diet and physical activity, as opposed to the other three. And to your point, we can't let this moment pass. Because this is something where we can spend a focus on—if the health-care community focused on GLP-1s and made sure they had it. I have to give credit to the Centers for Medicare & Medicaid Services. They've set up this Bridge program where seniors will pay $50 a month, right? And they're not going to—

Bertha Coombs 33:08

We don't even know how much it's costing the government.

Steven Anderson 33:10

No, but in our report, there's data in—

Bertha Coombs 33:12

And is that sustainable?

Steven Anderson 33:13

—there's data in there that somebody will be very enthusiastic about GLP-1s until they go pick it up and it's a $500 copay, right? But it doesn't refer them to the Bridge program where it would be covered under the program.

Bertha Coombs 33:29

If you're on Medicare. Not if you're on a commercial plan. So, that doesn't work.

Steven Anderson 33:34

But we need that coming from the payers as well, and put the priority on that to help these people. Because you check all the boxes on a lot of these other diseases. We can't let this moment pass.

Bertha Coombs 33:46

So, in the few moments that we have left, where will we be on this five years from now? Chuck?

Charles "Chuck" Henderson 33:58

I hope there's progress. I really hope there's progress. I think that—and not to talk politics, but instead of us being so divisive, I think this is a moment where the country spoke, and they're angry, and they want to see change, right? Because we have a huge affordability, accessibility problem in this country. And so, I'm just hopeful that we'll see some progress.

Bertha Coombs 34:27

Shantanu?

Shantanu Agrawal 34:28

A few things. I think there needs to be a reckoning on price. I do think there'll be more data and better understanding of how GLP-1s work and what timeframe for what populations. I think that's critical. And third, I do think we have to continue the conversation around food. It's got to be meaningful, and we have to support better nutrition for the whole country.

Bertha Coombs 34:47

Sounds great.

Steven Anderson 34:47

I think it's going to take leadership that we may not have in this country right now. Maybe we do. But we need to—five years is a long time. If you haven't been on a GLP-1, you're going to lose a lot of people in five years, right? There's a sense of urgency about this. Everything else, we say COVID was urgent. This obesity and all these other chronic—and that lead to all these chronic diseases—

Charles "Chuck" Henderson 35:10

Existential threat.

Steven Anderson 35:11

—should be a national emergency.

Bertha Coombs 35:13

It should be, as well. They're giving us the wrap. Gentlemen, thank you so much for the discussion.

Announcer 35:22

We hope you enjoyed the discussion—

Disclaimer: This transcript was reviewed by individuals for accuracy and serves as a reference. However, it may still contain errors or omissions. Please verify any critical information independently.