HOW DIGITAL PLATFORMS DRIVE LONG-TERM GLP-1 SUCCESS

Announcer 00:00

Please welcome the panel to the stage.

Bertha Coombs 00:16

Hello, everyone. Thank you for joining us, and thank you for joining us if you're streaming—joining us virtually. I'm Bertha Coombs. I call myself a recovering journalist, retired from CNBC last year, but still very passionate about health care. And we've got some amazing folks here with us. We are going to start with Angela Fitch. She is the cofounder of knownwell, which is a wraparound service and hybrid virtual and in-person service. Evan Richardson on the end is the cofounder of Form Health, and Jennifer Mazur, who is the head of LillyDirect, Eli Lilly's direct-to-consumer platform. One of the things I found very interesting is that all of these platforms and all of these services to help people with GLP-1, they are less than 10 years old. And as a reporter, I remember way back when, 10, 12 years ago, I did a story on one of these telehealth medicine groups, and at that point it was about one-off. And I was doing a story about the company, and I said, "Can you get me one of your clients?" And the client was a chipmaker, not Nvidia, and the chipmaker in Silicon Valley, and I was talking to the HR person, and the only person that they could find who had used it was someone in the HR office because she knew about it. So all these tech-savvy people didn't know about this thing where you could call someone and if you felt the flu coming on, you could get that script called in in five minutes. Fast-forward post-pandemic, and everybody, including payers, now believes that telehealth and telehealth platforms are a critical part. One of the things that you guys provide are wraparound services. And I wanted to start with you, Angela, because you had said that weight control has always been relegated to the patient. But now we're understanding, hey, we need to be there to help them. And how do these wraparound services make the experience different, especially when it comes to GLP-1?

Angela Fitch 02:26

Yeah. So we're really actually more than a wraparound service because we're providing full-service clinical care to patients. And we at knownwell, we created knownwell to be the patient-centered medical home for people with overweight and obesity, and anybody with metabolic health concerns, really. It's not based on your weight or a number on the scale, but really about your metabolic health. And so we wanted to do that in an insurance-based model where people didn't have to pay extra for it. And we recognize now that

obesity is a chronic disease. In fact, it's been since 2013 that the AMA, the American Medical Association, said obesity is a chronic disease. It's our number one chronic disease in our country, and it leads to multiple other chronic diseases. But it's the only chronic disease that's not a standard benefit on our insurance. So it's an elective benefit that employers or others have to choose to add in order to care for the patient. So because of that, the patients are having to seek this care for decades, centuries really, outside of the traditional medical system and seeking that care in other commercial locations. So it's been a very commercialized, by default unfortunately, type of care for a long time. And so again, I think that the idea that we're really focused on it's not about getting access to just a medication, but it's getting access to the care around that medication that's going to drive health outcomes long term.

Bertha Coombs 03:52

The access to the medication and the demand for the medication, I think it's one of the most incredible things in health care where this has been consumer driven, where people said, "Oh, this works. I want it." And Lilly responded by saying, "We're going to go direct-to-consumer," which we have not seen that before.

Jennifer Mazur 04:14

Yeah. We started LillyDirect on the premise or the provocation that we needed to simplify the health-care experience and remove all of the friction that gets in the way from being able to access independent care providers, get to that clinical decision, find the right treatment for you, and then you go through all of these hoops, as you said, to access the medicine, afford the medicine. And in some cases it's intentional friction that's put in the way between the patient and that path to better health. And when we launched LillyDirect in January of 2024, shortly thereafter, right around that time, it was less than 20 percent of large employers who were covering obesity medications. And again, obesity is a chronic disease and you look at other chronic disease medicines and you don't have the hurdles that you do for chronic weight management. And shortly thereafter in August of 2024, we decided to bring to consumers a direct-to-patient transparent pricing for the medication. We still believe in commercial coverage and other aspects of coverage. It's critically important. But in absence of that, when patients have access to that transparent pricing, especially in the moment of that treatment decision, to go through all of that effort to get to a provider, to find the care, to make the decision to start treatment, and then now you're at a dead end because you can't access and afford the medicine. That is really critical to the path to better health, and that's one of the reasons why we brought LillyDirect to market.

Bertha Coombs 05:44

I think one of your colleagues had mentioned to me once that it was something like one in three new patients comes through LillyDirect rather than through a script that was written by their doctor.

Jennifer Mazur 05:56

Maybe it's one in three are getting their medicines filled at the LillyDirect pharmacy. Because the LillyDirect Pharmacy is receiving prescriptions from all health-care providers. It's just like writing a prescription to any pharmacy. And for us, it's all about—with the access to the independent care providers, many people have a personal physician. So you see your personal physician, and then you should be able to access the self-pay pricing through LillyDirect. Some people don't, or they have a doctor and want to have a different conversation with a specialist. They want access to that virtual care. So that's what we

started on LillyDirect as well, was access to independent care providers, some who specialize in obesity. We also help support patients with diabetes, those with memory and thinking issues, alopecia areata. So we went beyond just obesity. But you're right, the demand for this scientific innovation is shining a light on the friction that has existed for patients in the US for decades. And what really excites me is that the solves that we are putting in place for the patient seeking management for obesity is going to be the exact same rails that we can improve the health-care experience for all other diseases.

Bertha Coombs 07:13

That's what one would hope. Evan, a lot of employers go through companies like yours, Virta, and other—

Evan Richardson 07:19

That's right.

Bertha Coombs 07:20

—to try to help patients contend with this. Does that make a difference? Because I think about the fact that people are just given a drug. And I know my late mother, she was given a drug, but she didn't know how to handle it. And this was just for hypertension. But she had certain titrations and things that she had to take, and if we didn't manage it for her, she probably never would have done it.

Evan Richardson 07:49

Yeah. Look, I think the answer is yes, it matters, and there's two key things that matter. One, does the employer cover it at all? What we see is when the employer provides coverage to their population, obviously, maybe not obviously, access is way higher. You see a lot more patients that get access to those medications and are able to take advantage of it. But you mentioned the second piece, which is also really important, making sure that those patients don't just have access to a medication, but that they have expert care as part of that. And that's what we do. We are now the nation's largest specialty provider of cardiometabolic care. We do, like knownwell, provide that in a wraparound model. So when a patient comes to Form, they get an expert ABOM specialist, American Board of Obesity Medicine subspecialist.

Bertha Coombs 08:32

I was going to say, ABOM, wow.

Evan Richardson 08:33

That's a good one, right?

Bertha Coombs 08:33

It's like an atom bomb specialist.

Evan Richardson 08:35

That's inside baseball lingo.

Bertha Coombs 08:36

I love that.

Evan Richardson 08:36

That's American Board of Obesity Medicine, so board-certified subspecialist. And this is a subspecialty. Yeah, absolutely. They walk among us. They're fantastic. They are specialists that know exactly how to treat this area of care. Every patient works with one of those individuals. They work with a broader care team, a registered dietitian, and that's exactly the kind of wraparound care. What we see is it's not just the medication that makes a difference, it's the medication plus that high-quality care that allows patients to see outcomes—

Bertha Coombs 09:05

Or adherence, right?

Evan Richardson 09:05

And the adherence.

Bertha Coombs 09:05

Because a lot of people start and then—

Evan Richardson 09:07

That's exactly right.

Bertha Coombs 09:08

—they drop off, because they can't deal—for a lot of them, they can't deal with the gastro symptoms and—

Evan Richardson 09:13

That's right. And I think the real-world data, and you correct me here, is something like the average patient these days has gotten a little better now that the shortages are over. The average patient stays on medications like these only for about five months.

Bertha Coombs 09:24

And is that enough?

Evan Richardson 09:25

That's not enough. These are medications that patients should stay on, in the vast majority of cases, forever. It's part of their care treatment going forward.

Bertha Coombs 09:33

That's what I was going to ask. So do you think this is something like a statin that you would—

Angela Fitch 09:37

Yes.

Bertha Coombs 09:37

—take forever?

Angela Fitch 09:38

Yes. Our data shows that overwhelmingly so in randomized controlled trials, which is the science, right? We don't want to believe the science today in multiple areas. But that's a whole other level of discussion. But the point is that we have randomized controlled trials that Lilly and others have done that show when people come off these medications, and in a randomized controlled trial, patients are taking placebo now randomly. They don't know that they've come off the medication. Technically, they kind of know because they know that the effects they were getting from the drug are not there anymore. But technically they don't know that they've been randomized to come off the medication, and yet they still, despite having visits with the clinical team. We do clinical research also out of knownwell. We've built a full-service clinical research division for our patients to access care in that way as well and to participate in the advancement of this science in the field. And patients are coming in once a week, every month, getting behavioral lifestyle counseling. So it wasn't like these patients just dropped off their medication and didn't do it and just threw caution to the wind. They were still coming in, and they're gaining weight back. On average, people gain weight back. And that's because in society today, we do not believe that obesity is a disease still. We still think that it's just about lifestyle intervention alone. But what we know, like other chronic diseases, you wouldn't treat your cancer only with lifestyle intervention, yet there's multiple lifestyle interventions that help make cancer treatment more successful. So in other words, it's a chronic condition that requires both medication, sometimes surgery and procedures, as well as lifestyle intervention. It's a multimodal treatment, not just a one and done.

Bertha Coombs 11:16

Like many chronic conditions, they are inflammation driven.

Angela Fitch 11:21

Yeah.

Bertha Coombs 11:22

Right? If I'm an employer and I have to look at my drug spend, talk about inflammation for my drug spend.

Angela Fitch 11:30

I think that's called inflation.

Bertha Coombs 11:32

Exactly. We call it inflation in that regard. And we have seen health-care employers say, “We’ll cover it for you if you’ve got cardiac. We’ll cover it for you if you’ve got type 2 diabetes, but we got to draw the line on obesity,” which contributes to the other two factors. So how do we get employers, and how do these services help employers factor in a return? Especially, they’re not just paying for the drug, now they’re paying for the services.

Evan Richardson 12:05

Well, I think one of the hard things if you’re an employer is you see the dollars going out the door for the medications that you may be spending on, and in a regular setting, you don’t see anything else. You can’t see whether your patients are getting outcomes. You have a real hard time seeing if there’s any improvement across your type 2 diabetes population or any of the other comorbidities of obesity. And so I think in a standard model, it really is tough. I think one of the things that we do is we are deploying care in a COE model. We’re typically a carve-out. We’re usually the only provider of obesity care inside of that employer when we work with that employer group. And so we can tell the employer, “Hey, here’s the patients that we treated. Here’s on average what their comorbidities were when they came in. Here’s where they are a year later. On average, you’ve seen this level of weight loss. You’ve seen 50 percent resolution of prediabetes. You’ve seen 60 percent resolution of hyperlipidemia,” and on and on. And now they can start to connect those dots. Now, if the CHRO is talking to their CFO, it’s not just, “Holy smokes, how did we spend this much money?” It’s, “But look at what we’ve gotten.” Right?

Bertha Coombs 13:04

But some part of the problem for employers is that this is a front-loaded investment because eventually—

Angela Fitch 13:11

But if everybody—

Bertha Coombs 13:12

After two years—you might not have to put a stent in, you might not—God forbid, have some sort of aneurysm or something. But in the meantime, you got to pay for it now, and a statin is a lot cheaper.

Jennifer Mazur 13:29

It is now. It wasn’t when it first launched. So I think that’s what’s interesting too about this evolution. If you look back at, gosh, with cholesterol, it was your LDL is 100, you don’t have diabetes, you don’t have other risks, but we should treat you and get you down to an LDL of 100. And that took a while to get the treatment paradigm to shift for diseases like hyperlipidemia. And I think we’re on that similar path for chronic weight management. And you’re right, it takes time for the outcomes. You see the early indicators of outcomes, as you mentioned. And we know enough about the science in other disease areas that those early indicators and long-term clinical studies prove out and reduce significant cardiovascular risk, but it takes time to prove that out from a money perspective. So if you’re concerned just about your fiscal year budget, I think you’re bringing up, Bertha, that’s the problem is we have to take a longer horizon view on the overall impact that we’re having, societal impact, really.

Angela Fitch 14:30

And we have to all do it together. Because, again, if all the companies did it or if they were mandated to do it in some way, shape, or form, meaning if we had standard benefit coverage, that it was just required to have obesity, because it should be. Actually, the ACA says that if you have a disease, you should have to cover it. And so we should have standard benefit coverage for obesity in the country, but we don't.

Bertha Coombs 14:54

So do you think a GLP-1 should be a preventative service?

Angela Fitch 15:00

Well, not necessarily a preventative service, but more of a—I think in the future, there may be some data that these medications have the potential towards that. We don't have that data yet today to show that, but I think it should be definitely a standard benefit, just like diabetes is. You can't just say as a company, "I'm not going to cover diabetes treatment." You can't say that because it's a standard benefit that you have to offer. And so again, but they can say that they're not going to cover obesity, and that's because it has been a carve-out since early days because it was thought to be aesthetic. It was thought to be in the 1950s when we created insurance or whenever that was. We said, "We don't cover aesthetic things. We don't cover facelifts. We don't cover liposuction. That's aesthetic." And that's what obesity was thought of.

Bertha Coombs 15:42

And that the problem was just a—

Angela Fitch 15:44

A personal failure—yeah, it was a personal failure. And many patients come in feeling that way, and that's the thing that we have to change societally. And by saying we don't cover it, it also reinforces that stigma that it's not important enough, right? And if all people did it, we would all benefit, right? That employer wouldn't be upfronting, everybody would sort of be upfronting in order to advance all of our population health. Lilly produced data in a study, randomized control trial, showing a 94 percent relative risk reduction in developing type 2 diabetes if you had prediabetes—94 percent. We don't have anything that's 94 percent relative risk reduction. That's really good. So if we had a population, imagine a population health campaign from some—I heard earlier in a session that the great thing about Milken is it brings together nonprofits and for-profit and all other types of people, philanthropy. Why don't we have a huge philanthropy that funds something like this, right? And put some money towards it. Because if we identified everybody with prediabetes and we were able to get them on treatment, we could essentially eliminate type 2 diabetes in the next 10 years. We could essentially, for the most part, not have to deal with type 2 diabetes and its ramifications. But we're not thinking about that because all we see are the dollar signs.

Bertha Coombs 17:01

Well, but you have to write those checks, right? And you need the cash flow. One of the things I find very interesting is that HHS has looked at, and CMS has looked at these trial programs for specialty drugs like the sickle cell drug to create, I guess, sort of a fund where everybody can go in, and those are separate

from everything else. And I wonder with something like this where you have such a huge population, is that something feasible? Like the Bridge program—

Angela Fitch 17:33

Bridge program is one example—for everybody.

Bertha Coombs 17:35

Something for everyone.

Angela Fitch 17:36

Bridge for all, that's what I would like to have.

Bertha Coombs 17:38

And employers could pay in. And obviously the Bridge program is only here till the end of next year, so then what—

Angela Fitch 17:45

Well, hopefully it's still—maybe someone in here's working on it. Supposedly people are working on it. That it's not a bridge to nowhere, that it's a bridge to somewhere.

Bertha Coombs 17:50

Hopefully.

Angela Fitch 17:53

So let's pass TROA.

Bertha Coombs 17:55

But I mean, this brings up the need for different models, doesn't it? In terms of financing. Someone was talking about how maybe we shouldn't just do this one year at a time and do longer contracts instead. Can you do that with—

Angela Fitch 18:13

It is very ripe for value-based care, obesity. Once the price of medication, if one can negotiate with a large pharmaceutical company to potentially get a price point that would fit within value-based care, I think clinics like myself and Evan's could deliver that value-based care, could deliver on that. 87 percent of our patients are still on their medication at two years. Not 30 percent, like the data shows out there, right? And I'm sure Evan has very similar numbers. Because people stay on these medications if you give them the care that they need—

Jennifer Mazur 18:44

The wraparound and the holistic approach.

Angela Fitch 18:45

Yeah. Instead of giving them the medication off of a form on the internet, and then they might not come back, or maybe somebody's emailing them saying, "Come back to us. Buy this product again." But it oftentimes doesn't work, because they really need that care that's wrapped around it as well.

Jennifer Mazur 19:02

That was one of our big learnings going direct-to-consumer. We were discovering and making medicines for 150 years, and this was the first moment that we went direct-to-consumer with a platform and with medicine. And while we had patient support programs that extended beyond the medicine itself, trying to help patients get the most out of their medicines, it was educational and largely not personal. And when you go direct-to-consumer, we saw aspects of the friction in the health-care experience that we sort of intuitively knew was there. But to your point around, it's not just at the point of prescription and you go, "Okay, we're good." The prescription process itself is fraught with friction, and there's the first prescription and then the dose escalation and the refill and the renewal, and electronic systems are breaking, so even that's fragmented. But to your point, when you go beyond just that moment for the patient who's, "Am I getting the most out of this? Am I doing this right? Am I progressing the way that I should? Am I plateauing? What do I—" There's a lot of questions that they have and need that continued engagement. I think that on the value-based agreement side, not only does the GLP-1s present such a great opportunity for that, but the digitization of health care helps support that. For quite some time, as you try to bring value-based agreements to market, it requires a lot of the physician and the system to do the tracking mechanisms, and did we achieve the outcome or not? It's burdensome.

Evan Richardson 20:33

It is burdensome, but if you build the software tools around it to do that automatically so the physician's not having to deal with it, I think it's ripe for that exact kind of disruption—

Bertha Coombs 20:42

Biometric data, 24 by seven attached.

Evan Richardson 20:44

Absolutely. And the demand is certainly there. You told the story about one person at an entire company using one of the first-generation digital care tools. We see it is not uncommon in our employer population to see one in 10 as patients of Form. It is not uncommon—

Bertha Coombs 20:59

Which still doesn't seem like that big a deal, considering the rates of obesity—

Evan Richardson 21:02

But we're literally the most frequently used care provider in their entire benefits stack, right? So we have more patients than any other provider that they might work with. So it is a real difference from where things have been, and you're right. With the right tools, it becomes a population health story more than anything else. That's certainly how we talk to employers.

Bertha Coombs 21:20

And how do you show the ROI? Because to me, one of the things that's exciting about what you guys do is closing the loop, right? You don't just look at them and say, "Oh, yes, we're going to help you deal with this drug," but what are the other metabolic issues that you have?

Angela Fitch 21:37

Yeah, we deal with their menopause, we deal with their hot flushes, we deal with their lipids, we deal with their sleep apnea. All the other comorbidities, and other issues that people have in their life that affects not only their quality of life, but also their metabolic health, as it relates.

Bertha Coombs 21:56

Including mental health, right?

Angela Fitch 21:58

Mental health, yeah.

Bertha Coombs 21:59

I can tell you that I know about controlling my weight, but during the pandemic, and with the stress of caregiving, the stress of the pandemic, it was like, coffee chip ice cream was my drug of choice. That's—

Evan Richardson 22:13

It is really good.

Bertha Coombs 22:13

That's what made me feel good.

Angela Fitch 22:15

It's delicious.

Bertha Coombs 22:16

I know. I know that whatever, 30 grams of added sugar was not what I needed to be having. But at the time, that helped calm me. So how do we help people get beyond the stigma and beyond the silence? Because oftentimes that's the problem. I have a doctor friend who had said when it came to weight, "I would see someone and I would say, 'Are you open to a discussion about your weight?'" And before GLP-1s, people would be like, "No."

Jennifer Mazur 22:50

I think I heard a statistic, most people will go through 11 cycles of failed diet and exercise even with GLP-1s available today, before there is a meaningful conversation with a clinician, especially a primary care. They don't specialize in obesity. Difficult conversation to have if you as the patient aren't bringing it forward. So, it is. And again, we all have people in our personal lives, I presume, that have been on a GLP-1 medicine. I'll speak for myself, my family members, it's not because they had a lack of personal discipline. It was a real metabolic disorder, and it has really made an impact. So I think that that's overcoming that stigma—huge very first step, I think, for consumers. But then also demonstrating to that patient, obviously you see it has a physical aspect to the disease, so you see the changes, but it's so important to highlight the other aspects, the metabolic changes, everything that is happening, and reinforce continued engagement with treatment.

Evan Richardson 23:55

I think it's always going to be hard to have that outside-in conversation. Maybe not always, but for a long time. The question that starts with, "Are you open to talking about this?" That's tough. I think what we see, which is really awesome, is the flip side has become really easy. Patients will say, "Holy cow, Evan, you look amazing!" And now, there was a period of time where there was actually shame even around saying, "Well, but I'm getting treatment." And what we see is that's now unlocking. Patients are now willing to say, "Well, I'm working with Form, I'm working with knownwell. I'm having this success because I'm using different tools." And then holy cow, does that unlock a different conversation now for the person who asks. So I think, when it starts that direction, it's okay.

Bertha Coombs 24:32

I would imagine that that helps the HR person say, "Hey, everybody's really excited about this." Because I remember one of my colleagues, I was like, "Wow, you look terrific. What have you been doing?" He goes, "Well, I've been on a GLP-1, but I've also been..." He also did the wraparounds. He'd been doing the exercise, and he's been in contact with a care provider about this. Can you show the ROI, and do you have to set expectations about when we get there in terms of, this is not going to happen in three months, this is not going to happen before your fourth quarter?

Angela Fitch 25:09

Yeah, there have been multiple publications to this point and multiple peer-review journals that support the ROI on this type of treatment. And again, like I said, with the randomized controlled trial on the development, prevention of type 2 diabetes in people with prediabetes. We have the data. I think we just need to continue this mission of momentum to try with the Bridge program, as a really good example of finally getting access. Joe Nadglowski in the audience, the CEO of the OAC. I'm on the board of the OAC, in full disclosure, the Obesity Action Coalition, we're the patient advocacy arm for people living with obesity. And so the advocacy work that we've been doing for decades to try to and our counterpart, Christy Gallagher, too, that's sitting over there. Tirelessly working for the past 10 years to try to get something like Medicare Bridge or some coverage for our Medicare beneficiaries. And so again, I think the time is now. We're really reaching this crucial point where we all need to come together as a society and recognize the value of this treatment is greater than the cost of it today.

Evan Richardson 26:21

And I think that's right. And I would say, I think you can show it in a one-off employer interaction, too. We show it for our employers. One of our earliest employers, a big telco, and here about a year ago, they were up on stage and they said we were the highest ROI health benefit they'd ever deployed. And so they see it—

Jennifer Mazur 26:37

How much did you pay them to say that? But it impacts employee—

Evan Richardson 26:39

It's a secret, all right?

Jennifer Mazur 26:40

It impacts employee retention. It impacts how they—

Angela Fitch 26:42

Yeah, employee retention—

Jennifer Mazur 26:43

Right? I mean, how they show up—

Angela Fitch 26:50

Look at Bank of America. The Bank of America CEO is very vocal about coming out and talking about this. And so I think more people, be like Bank of America.

Jennifer Mazur 26:57

And I think in absence of, or while waiting for the system to catch up, that's sort of like—I think we're not waiting. And creating models that say, "Okay, we need the system to catch up, and it should play a role here in traditional coverage." And in absence of that, again, going direct-to-consumer, being virtual and providing the telehealth services, having coverage, accepting cash, transparent pricing. Lilly launched an Employer Connect platform where again, we're trying to also talk to small and large employers.

Bertha Coombs 27:30

I'm sure the PBMs love that so much, the pharmacy benefit managers.

Angela Fitch 27:33

Well, but that has to evolve though, too, right? That's what we're seeing with this as an example, I think, is that we need some evolution there. We need some new innovation in how we get care to patients. Because, again, when we started knownwell as a small employer, we couldn't get coverage for GLP-1s. As a small employer, you can't buy coverage. The Obesity Action Coalition as an employer cannot buy coverage for its employees as the largest advocacy organization.

Bertha Coombs 27:58

So then what do you do for your employees?

Angela Fitch 28:00

Well, you do it outside of that. You create this—there's all these companies now today that have created a benefit, essentially, where the employer can put money in, and then the employee can use that money to buy medication on places like LillyDirect or even their local pharmacy. The idea is like your health savings card, but you're putting money into it as an employer for this purpose.

Bertha Coombs 28:22

Because there are a lot of people who don't have access through their employers, a lot of people whose employer coverage is not that much, and they need it and want it, but they can't afford it.

Angela Fitch 28:31

Well, the biggest travesty, too, is that right now, as far as treating obesity, it's a have and have-not situation. And so we're treating people that have means and have resources and/or are spending those resources on choosing to spend $10 a day on their medication instead of spending it on something else. They're giving up something else to do so. And again, that's something that is really the travesty. And more and more states, unfortunately, have drawn back on their Medicaid. This is ObesityWeek in DC this week, so I'm heading over to the Gaylord after this to start that ObesityWeek, and one of my presentations is on Medicare and Medicaid coverage of this class of medication.

Bertha Coombs 29:12

What do you see next year as we're seeing cutbacks?

Angela Fitch 29:16

Unfortunately, Medicaid is cutting back because, again, it's not a standard benefit. They don't have to cover it. And anything that you don't have to cover, I think you're going to look to cut when you're making a budget. Because you can't cut the things you have to cover.

Bertha Coombs 29:29

But the irony is to see the state of North Carolina that doesn't pay for it for its employees but was paying for it for its Medicaid recipients, where they realized this is an important investment to do.

Angela Fitch 29:41

It's our most important investment, I think.

Jennifer Mazur 29:43

Well, I hope to see with the consumer demand, and any other—if you go outside of health care, consumers pay with their wallets, and they can walk away. And that forces change in that particular system or in that business.

Bertha Coombs 29:57

Well, especially as they went to the compounders, they went to the direct-to-consumer—

Jennifer Mazur 30:01

And this is the first time really in health care, I think consumers are taking more and more agency of their health and those health decisions. And it's starting to force—and once you get that convenience and that transparency in one aspect of the health-care experience, it's almost like the blindfolds were taken off. The expectations go up, and now you see consumers expecting choice, transparency, and convenience.

Bertha Coombs 30:24

So we talked about statins, and I remember 20 years ago when they came about, and it was just, atorvastatin was an amazing thing, Lipitor. Now, my husband gets his statin with no copay because that's such a good thing. Don't tell your bosses, but—

Angela Fitch 30:45

They're her bosses, not our bosses.

Jennifer Mazur 30:48

They're watching.

Bertha Coombs 30:49

Is it going to take 20 years for us to get to that point where we look at GLP-1s as just a basic thing that people should have?

Jennifer Mazur 30:57

It won't take 20 years.

Bertha Coombs 30:58

And at that accessible—

Angela Fitch 30:59

Five.

Bertha Coombs 31:02

—point. You think five? Really?

Angela Fitch 31:03

Well, there's a company, a competition to Lilly that has that as their mission—that they want to make the most affordable, cost-effective GLP-1 and get it out to everybody. Hopefully, these guys will do that first. That would be my hope—Foundayo for all. That's the program.

Jennifer Mazur 31:20

I can't speak to the pricing. But I can say, though, if you think about it, Lilly was the first company to step forward and say, "We're going to create a direct-to-consumer, self-pay price" that was significantly lower than the list price and that a patient was told they had to pay at the pharmacy counter. Again, to go through all of that effort to overcome the stigma, seek treatment, get diagnosed, get your prescription, and then the sticker shock at the pharmacy counter.

Bertha Coombs 31:48

So you think in five years we are going to get something that's much more affordable. Evan, where do you see us in five years?

Evan Richardson 31:52

Look, I think that we will probably look at something like 20 percent population-wide utilization on an ongoing day-to-day basis in three to five years. I'm maybe a little less optimistic about how quickly prices will drop across the board. I think that there's lots of new innovation coming. There's many new molecules coming. Those will be introduced at higher prices. Those will have a tiered set of prices and impacts. That's where I think we'll sit in five years, but I think the utilization is going to be way higher. 20 percent, 25 percent, something like that.

Bertha Coombs 32:28

And what do you think LillyDirect will do? One of the things—and I hate to throw this out here with two minutes left, but I'd love to see this as a model for someday when we have a really effective treatment for Alzheimer's, which is another ginormous market and we can't put price in the way of something so critical.

Angela Fitch 32:53

This is it. Let's do it—obesity, care for all, bridge for all.

Jennifer Mazur 32:58

It will. Like I said, it'll create the rails that will pave the way, I think, for all other chronic diseases to reduce friction. With Alzheimer's disease, for so many people living in rural areas, even if you live in a city, to get access to a neurologist, to get the diagnosis, six to 12 months go by. And for treatments that are—even for earlier-stage disease, by the time you get to the point of treatment, it's too late. The disease has progressed too much. There's too much innovation out there, and I agree, I think more and more innovation is going to create more choice. It's going to create more transparency, and I think that consumers, you can't take away the agency they have now, the empowerment and the information they have now to make decisions about their health care with what's been created with obesity, and I think that

will become the expectation. And the winners, all across the ecosystem, the winners will be the ones that drive choice, convenience, and transparency with quality. Do not forget quality.

Bertha Coombs 34:00

That's the other thing I worry about, that people are going to all sorts of—

Angela Fitch 34:04

I worry about the quality myself, too, because I think the quality is very important. The reason we have 87 percent of our patients still on these medications at two years is because we provide high-quality care. I'm not sure high-quality care is deliverable via only text messaging, like asynchronous messaging. That's what I worry about.

Bertha Coombs 34:27

Or an AI agent that says, "Hey, you look great."

Angela Fitch 34:30

I think there's so much opportunity for it, for sure, meaning this is definitely—we are building this into it. And I did my first telemedicine visit in 2005. I was probably that company providing to that HR. We were doing it with Blue Cross Blue Shield of Minnesota, and we did it in 2005. We were doing it. It was dial-up still. It was going when the internet came on. You know, right? You remember how it did that, it went … Anyway, this is not new. Like you said, it took 20 years and a pandemic for this digital care to become standard of care. But the good news is we are writing the standards of care for obesity right now, the ADA standards of care for obesity, and you can check those out. Those are free online. Everybody can access them. And this is all going to be part of that standard of care.

Bertha Coombs 35:20

Perfect note on which to end. Thank you all so much for a great discussion.

Announcer 35:28

We hope you enjoyed the discussion. The next panel will begin shortly.

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.