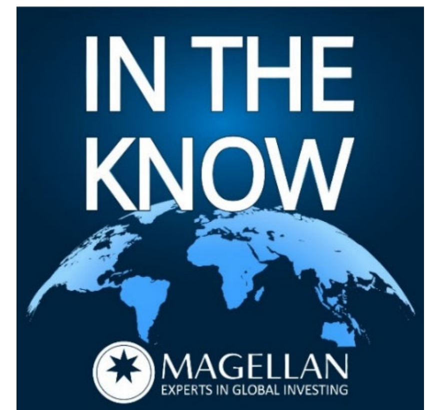
Magellan – In The Know: Special Bonus Episode

Insights from the US: An update on the Impacts of GLP-1 on healthcare systems



Announcement (00:00):

The information contained in this podcast is for general information purposes and does not constitute investment advice. You should seek investment advice tailored to your circumstances before making an investment decision.

Host (00:14):

Welcome to this special edition of Magellan In The Know, where we provide an update to our recently released episode on the popular weight loss drug glucagon-like peptide-1, or GLP-1. Magellan investment analyst, Wilson Nghe recently returned from the US with insights on how commercial players and policymakers will approach not only reimbursements of GLP-1, but the future of care delivery in the US healthcare system. In this episode, Wilson sits down with portfolio manager Nikki Thomas to discuss what he has learned on the ground in the US from the companies and experts he met with, and outlines the potential cost implications GLP-1 reimbursement could have on the US healthcare system.

Nikki Thomas (00:58):

Hello everybody. It's lovely to be here today. I have Wilson back with me having just been on a trip to the US, and we thought it would be great to give an update on all of the learnings he's had while in the states discussing this issue around GLP-1s with companies and experts and people in Washington, DC, so a really productive visit. So why don't we kick off, initially Wilson, with this reimbursement question which we raised in the last podcast, the challenges relating to GLP-1s, I think you had an expert that said it could potentially bankrupt the system. So, what did you learn in talking to the commercial payers and their willingness to get on board with this?

Wilson Nghe (01:38):

Yeah, so I had the privilege of speaking with the CEO of the largest health insurer in the US, United Healthcare, which is one half of United Health Group. And look, it's clear that the private payers in the US, they all agree on the clinical trial data and the long-term benefits of GLP-1, much of the stuff we spoke about last time. And they do so in very much the same way that they agree on the efficacy of new, early Alzheimer's treatments, or the range of gene therapies, that are currently undergoing development. But the key difference with GLP-1 is the benefits that we talked about. So cardiovascular risk, kidney disease benefits, it's actually less immediate, right? So it's a long-term prevention, or reduction of risks, of diseases. And the important distinction here, and we spoke about this last time, is you actually need to stay on therapy for a long period of time, or even life, to actually see some of these benefits.

(02:29):

The thinking behind the GLP-1 reimbursement argument is you pay for these drugs upfront, and you save on the future healthcare costs where the patients might not need to go on treatments for the range of comorbidities that are associated with obesity. But the reimbursement conversation becomes harder, particularly when high-efficacy drugs, like Wegovy and Zepbound, have a cost of ballpark $1,000

US dollars, or more, a month. And to actually pay for these drugs upfront for an uncertain future on how patient adherence looks like, and whether they actually stay on these drugs long enough to see the benefits, becomes harder to justify. So it's not to say health insurers shouldn't pay for these drugs, it's more that at the current prices it's just not meeting their cost-benefit analysis.

Nikki Thomas (03:16):

Yeah. Okay. So simplistically, it's kind of you reimburse a big amount of money here, but in five-years time, if people haven't kept taking those drugs that you've paid for the benefits you thought you were going to get in much better comorbidity outcomes, may not happen if they stop taking it. So it's very hard for them to juggle this issue. What are they saying is the potential solution to that, then?

Wilson Nghe (03:39):

There's two catalysts that might solve this reimbursement issue. So the first one, and we touched about it last time, is essentially if the prices of these drugs come down further to a point where it actually becomes easier to justify on a cost-benefit analysis, this makes a reimbursement conversation a lot easier to manage. And a lot of this will come from greater competition on the GLP-1 drug front. So, pharma producers outside of Eli Lilly and Novo actually commercialising competitive products should help drive prices down. The second catalyst is commercial payers like United Health have started discussions with pharma producers on some sort of a risk-sharing agreement. So this is not too dissimilar to the value-based care contracts that they have in the other parts of their health insurance business. It's where they essentially share some of the financial risk with the pharma producers in the event that patients do not adhere to the drugs.

Nikki Thomas (04:34):

Okay. So it sounds to me like there is a risk that this actually inflates the overall healthcare cost. And as many of our listeners will know, the US already has the most expensive healthcare system in the world that costs the government an enormous amount of money. What were the learnings that you got? You obviously went to Washington, DC. Talked to people on Capitol Hill. What are you seeing around the trends on US healthcare costs in general?

Wilson Nghe (05:01):

I managed to make a trip out to Washington, DC, and spoke with a couple of people from both sides of Congress, so from the Republicans and Democrats who are intimate in shaping how healthcare policies evolve. As you pointed out, we know health system costs in the US are largely unsustainable. It contributes something like $1.5 trillion to the current budget deficit. What was most important from the trip was there is a clear support from both sides of party in terms of bringing down health system costs, and it's increasingly becoming a more important agenda item for new policies that come through government. I'll just talk through two key policy initiatives that I discussed with them at length. The first one is the IRA, and we touched on this last time, but that is a big first step for the government to take. It's the first time that the US government, who is the largest single purchaser of drugs in the US, is actually able to flex their bargaining strength and negotiate down-list prices.

(05:59):

It looks like there's very little to no risk of legislative repeal, or change, on this policy regardless of which party comes into power in the next election. It's a policy that's proved very popular with voters, particularly seniors, who ultimately see benefits when they pick up their prescription drugs from the pharmacies. Our view is, we still remain cautious on a couple of the pharma names where there are a number of loss of exclusivities on drug assets where there's been high spend by Medicare historically, and where we don't have conviction on their ability to replenish that pipeline.

(06:32):

The second learning was on value-based care and Medicare Advantage policy. So this aspect of healthcare policy is gaining more and more bipartisan support despite what we're seeing in some of the media headlines that have come out. There is support from both sides and its ultimate aims in, not only improving healthcare access and healthcare outcomes, but also tying these directly to reimbursement. The US is continuing this journey from moving from volume-based healthcare payments, where physicians or GPs, get paid simply by seeing a patient, to one where the GPs are actually tied to whether there's evidence of patients improving healthcare outcomes. We should expect a continued tailwind on government reimbursement in relation to Medicare Advantage programmes, and the one positive is for United Health Group, who has the highest number of Medicare Advantage policies.

Nikki Thomas (07:22):

I feel like we might be getting even ahead of the market here. This is going to be a topic that's really, I think, going to jump to the top of the discussion as we go through next year, just because we're coming into a US election in November next year. Fantastic that you've got these insights kind of early in the piece, I think. What would you say, and you mentioned United Health, obviously we'd like to bring this back to the portfolio. What's your main takeaway in particular around United Health from the trip you just had?

Wilson Nghe (07:53):

Yeah, so, if you look at how healthcare delivery is being managed in the US, the view that I came across from the company meetings and the meetings on Capitol Hill was United Health plays right into this overall aim of the government to not only improve healthcare outcomes and access, but doing so in a much more efficient manner than they've done in the past. So, United Health, they're the leaders in the health systems shift to value-based care. They've built the necessary infrastructure to actually deliver a lot of the value-based care outcomes. This is from having everything from pharmacy services to housing important healthcare treatment data, to also having the largest physician, or GP network, in the US. And they've built up this infrastructure over much of the past decade. And what we're seeing is competitors in this space are really struggling to actually catch up to United's vertically integrated and diversified offering.

(08:49):

What's also interesting is that you're actually seeing United Health having this infrastructure being able to then innovate in what is typically a very archaic industry, right? Health insurance. So what they showcased from some of the meetings was some of their new offerings, which has actually helped United Health gain share with a lot of the customer contracts, which has changed hands over recent years. So one example is, they're actually able to show consumers how much a procedure costs at different hospitals, or surgical centres, and where the consumer chooses to visit a lower-cost surgical centre. United Health actually rewards them. There's this whole movement of actually increasing consumer empowerment in how they want healthcare delivered to them and how they want to be treated. The last point on United Health I'd make is we actually don't view the valuation as overly demanding or expensive for the business. And from the US trip and some of the meetings in DC, I think the market's somewhat overplaying some of the shorter term reimbursement fees around Medicare Advantage and the new risk adjustment payments that are coming in.

Nikki Thomas (09:53):

Thanks, Wilson. I guess from the portfolio perspective, I could just double click on a couple of things Wilson said. We've got a business here that has scale and leadership in its marketplace. We have really strong management, and this business has really differentiated itself around this value-based care and is

well ahead of its competitors in where it's moving health insurance in the US. I thought it was interesting while you were away, we saw a brief moment of discussion between two other players, Cigna and Humana. Obviously it went away again quite quickly. Did you talk to people about that while you were there, or what are your thoughts on what was going on there?

Wilson Nghe (10:32):

Yeah, so that was a very interesting bit of news, whilst interestingly United Health **Host**ed their investor day. As you pointed out, there was media reports on Cigna and Humana who are key United Health competitors in merger talks. Ultimately, the deal fell over not too long after these media reports came out. Antitrust was an element of that, which I think is actually prudent given some of the meetings I had. They really stressed further consolidation in vertical integrated healthcare companies is increasingly high up on their watch list.

(11:04):

What this really shows for us is competitors in this space are struggling to compete meaningfully with United Health Group on their own. There is a need to expand value-based care offerings to compete with United Health, and this means actually needing to build the necessary infrastructure, the things we talked about, like having a scaled pharmacy services business and having a large network of physicians and outpatient centres within their business model. There is also a need to gain scale and diversification across all the key payer segments in the health insurance side of the business. So, it's things like not only within the commercial book, but also with Medicare and Medicaid books of business. And as we talked about earlier, United Health has started this journey well ahead of peers. We are very comfortable with United's head start, and this whole consolidation piece with healthcare companies coming into the government's crosshairs. It's essentially just added another barrier to competitors trying to catch up to United Health.

Nikki Thomas (12:03):

Yeah. So, got a first mover advantage and the government's making sure it gets wider. That's a pretty nice business to own. Obviously, comes with a nice defensive tilt to it as well, which is great in terms of the mandate that we have in the global strategy. I know when you got back, we had some fun discussions about time you spent in labs and talking to surgeons, but is there anything else that you'd learned in all of these other investigations that you were doing while you were in the US that you think would be interesting for listeners?

Wilson Nghe (12:31):

Yeah, so I think overall the main aim of the trip was really centred on knowledge gathering on where the future of care delivery will be within the US health system. As we know, the US is responsible for the bulk of new medical technologies and discoveries, and we've actually seen over the recent years an acceleration of important innovation and findings in pharmacology, medical instruments, cancer screening. We've also seen a lot of new sub-segments in healthcare increase in prominence over recent years. So things like genomics medicines, which is rapidly shifting from research into the clinical field. So the trip was really about ensuring we were comfortable with our healthcare exposures amidst all this change. I had the opportunity to meet with one of the largest pharmaceutical groups in the world, so Novartis and learn about the future of medicine and the upcoming pipeline in gene-cell radioligand therapy.

(13:24):

I met with a leading urological surgeon and learned about, and actually tested one of the robotic surgical systems that he uses to perform a lot of abdominal surgeries, and this will actually shape how surgeries

are performed in the future. And I also managed to visit one of the largest DNA sequencing labs in the US. They perform a lot of clinical and research genomics testing, and they're one of the largest buyers of next-generation sequences. And why that's important is these systems will underpin a lot of the future of cancer screening and rare-disease research. It was a very interesting and eye-opening trip. And I think all in all, it was a lot of learning about new technologies in healthcare delivery, and ultimately just being comfortable with how we're positioned with our research coverage, but also our exposures.

Nikki Thomas (14:13):

Thank you. It is such an innovative space always, but it does feel like there's a bit of a super cycle of innovation happening in healthcare on the back of some of the more recent changes and things like data and artificial intelligence. So, fantastic that you got that opportunity. I should just reassure listeners that when Wilson tested the surgical equipment, there was no patients involved. Thank you all for joining us and we wish you a terrific 2024.

Host (14:42):

That was Magellan portfolio manager, Nikki Thomas in conversation with Magellan investment analyst, Wilson Nghe. We trust you've enjoyed this episode. Join us in 2024 for our new series of Magellan In The Know. For more information on previous episodes, visit Magellangroup.com.au/podcast, where you can also sign up to receive our regular investment insights programme. Thanks for listening.

Units in the funds referred to in this podcast are issued by Magellan Asset Management Limited ABN 31 120 593 946, AFS Licence No. 304 301 ('**Magellan**'). This material has been delivered to you by Magellan and has been prepared for general information purposes only and must not be construed as investment advice or as an investment recommendation. This material does not take into account your investment objectives, financial situation or particular needs. This material does not constitute an offer or inducement to engage in an investment activity nor does it form part of any offer documentation, offer or invitation to purchase, sell or subscribe for interests in any type of investment product or service. You should obtain and consider the relevant Product Disclosure Statement ('**PDS**') and Target Market Determination ('**TMD**') and consider obtaining professional investment advice tailored to your specific circumstances before making a decision about whether to acquire, or continue to hold, the relevant financial product. A copy of the relevant PDS and TMD relating to a Magellan financial product may be obtained by calling +61 2 9235 4888 or by visiting www.magellangroup.com.au.
The opinions expressed in this material are as of the date of publication and are subject to change. The information and opinions contained in this material are not guaranteed as to accuracy or completeness. Past performance is not necessarily indicative of future results and no person guarantees the future performance of any financial product or service, the amount or timing of any return from it, that asset allocations will be met, that it will be able to implement its investment strategy or that its investment objectives will be achieved. This material may contain 'forward looking' statements and no guarantee is made that any forecasts or predictions made will materialize. This material and the information contained within it may not be reproduced, or disclosed, in whole or in part, without the prior written consent of Magellan.