4sight Health Roundup Podcast
Unlocking the Healthcare Market Implications of GLP-1 Drugs
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[Intro & outro music by C. Ezra Lange]

David Burda:

Welcome to the 4sight Health Roundup Podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, July 16th. This past Saturday, July 11th, I did something I wasn't planning on doing. I went on a GLP-1 drug; Zepbound to be exact. My doctor prescribed it to me to treat my sleep apnea. I had no clue doctors were prescribing them for sleep apnea, but they are, and I'm now one of them. I'm also now part of what we're gonna talk about on today's show, and that's the government's new GLP-1 bridge demonstration project for Medicare patients, kind of. I'll explain when we get into it with Dave Johnson, founder and CEO of 4sight Health, and Julie Merchanson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

Well, we're heading to our condo in West Michigan later today for the long weekend, or for a long weekend. That's our happy place, so I'm happy.

Burda:

All right. That's a good place to be. Thanks, Dave. Julie, how are you?

Julie Murchinson:

I’m in San Francisco, just for a quick trip down for,you know, a bunch of digital health nerds getting together, chatting up actually GLP-1s was a big topic last night. So, it's beautiful down here. I gotta say, California's got it.

Burda:

Yeah. Yeah. Good for you. Thank you. Okay, before we talk about Medicare's new GLP-1 bridge program, let's talk about your experience with GLP-1s. Dave, do you know other people besides me who are on them? And how's it working out?

Johnson:

Well, you know, Dave, it's hard not to know other people. And 11% of the US adults are on this. That's 30 million people. So I know several people, and honestly, I haven't heard anything negative about the side effects of the GLP-1 drugs. Just the opposite. Most consider them miracle drugs and, it often starts to trigger other healthy behaviors, eating better, going to the gym, that kind of stuff. So -

Burda:

Yeah. Yeah. No, I hear you. Thank you. Julie, how about you? Any friends, family, or colleagues on them? And, if so, what has been their experience?

Murchinson:

Yeah. I do know a handful of people who have, you know, it's funny, admitted that they've been on them. And I talked to one woman last night I've known for a very long time and two funny things out of that. One is she's gone up to a pretty high dose now and nothing has happened. Zero. Like, nothing. So her doctor says she's, like, you know, such an edge case. So I think find that fascinating. I have not heard one of those cases before. And then, of course, also, she told me all the stories of all the people and judgment she's gotten since she's really gone

quite viral on social that she's on them. So it's just, it creates so much good conversation.

Burda:

Yeah, it's the first time for me and I'll let you both know how it works out. But I asked my doctor to prescribe it to me through my regular Medicare Part D plan, not the Bridge Program, and, I'll explain why. My plan approved my doctor's prior authorization request and my copay for the first four doses was $685.89. It will drop from there as I hit my $2,100 out - of-pocket maximum. Thank you, President Biden. It would've been $50 a month under the GLP-1 Bridge Program, but I want no part of Dr. Oz as CMS administrator, RFK Jr. As HHS secretary, and certainly Cheeto Jezuz's president. If you recall, Biden proposed regulations in November 2024 that would have allowed Medicare to cover GLP-1s for weight loss. Medicare already covered them for medical conditions like diabetes. CMS under Trump scrapped those regulations saying it would be too costly, but CMS came back this year with the GLP-1 bridge program that began on July 1st. The program runs for 18 months from July 1st of this year through December 2027. Eligible Medicare beneficiaries would pay only $50 a month out of pocket for their GLP-1s prescribed by their physician for weigh management and if they're not covered by their existing Medicare Part D plan. An estimated four million beneficiaries are eligible for the program. But that's not the only big GLP-1 news of late. A report from Trillion Health said the number of people on GLP-1s rose 636 from 2018 through 2024. The fastest growing medical condition for which they were prescribed was sleep apnea. Hello. A survey from Gallup found that 11% of adults are now taking GLP-1s. That's up significantly from just 3% in 2024. A survey of about 200 employers by the International Foundation of Employee Benefits Plans found that 27% of the companies are encouraging their workers to get their GLP-1s through a direct consumer platform, not through their doctor. And a research letter published in JAMA said a researcher posing as a patient

was able to get a GLP-1 prescription from 45 of 49 consumer websites by doing little more than filling out a questionnaire. Dave, what's the good news and bad news here? What are the policy implications? And where are we with GLP-1s a year from now?

Johnson:

Well, it's more good news bears than bad news bears, I think by a lot. And we'll get into policy implications and, and uptake in a second. But first, this bridge program is responding to an intense and increasing demand for the GLP-1 drugs. You know, one of the real rules of business is, and maybe the most important rule of business is, give the customers what they want. People want these drugs. Two, and even more importantly, this bridge program provides an almost unprecedented opportunity to undertake massive observational research trials to determine the efficacy of the GLP-1 drugs as well as measure and document their beneficial and detrimental side effects. The amount of potential knowledge increase that can come from this program, , is just astronomical. I'm really looking forward to reading <laugh>, you know, these in - depth studies of, you know, millions of users ultimately and what the drugs actually do. And related to those first two benefits, meeting demand and then learning, you know, knowledge gains on the bridge program. I think this will, along with all the other ways to get the GLP drugs, turbocharged the movement toward personalized medicine and better, , overall population health, , for the American people. And if I'm right about that, , we c - we, we, we, we couldn't need that more, right, , as, as a society. , On, on the bad news, , front, , it probably, you know, I guess I'd focus primarily on the costs. , Medicare is, is paying, , Lilly and Novu Nordisk, the drug manufacturers, $245 per month per individual prescription. , That $195 per person subsidy will, will add up quickly. , But few things to think about on the cost side. , First off, the GLP-1 drugs, , have made Lilly the first trillion dollar medical company in history. They aren't gonna slow down anytime soon in their research to continue to develop the various types of, , GLP-1 drugs and, , their

applications. And everything I hear is we're, we're still at the very early stages of realizing, , the benefits and it didn't take that long to get a pill form of the drug, did it? ... Well, anyway, I related to the Medicare cost program, it, it's, and it's a small feature, but the $50 a month copay does not count toward Part D deductibles and out-of-pocket maximums on insurance. , So that will, that will blunt the cost a little bit. , But I, I think overall, it's gona be a very expensive program. But having said that, you gotta believe prices are gonna come down with, with broader market access and intense consumer demand. They already have. , Wasn't that long ago that the monthly cost for Wegovy, , Novu Nordisk's, , weight loss version of GLP-1 was $1,350 a month and, you know, that's, that's now down to 245 for the government. , That gets to my final point. I'm not sure where you found that $4 million number for the estimate of the uptake on the program, but that seems, , wildly low to me. There are already 30 million users, as I mentioned, of G- GLP-1 drugs. , 80% of elderly Americans, the ones that qualify for Medicare, , have elevated sugar levels and are already diabetic or pre-diabetic. That's 50 million people. So the train is on this has already left the station. It does take some time, , to get into the broader population, but I, I think we're well into the adoption curve, , on GLP-1 drugs. I mean, I remember in the early '90s, everybody I knew was on the Atkins diet. , And everybody got off it. , You know, turns out that eating only eggs and meat really isn't that great. And once you got off, off Atkins. Right. But I, I remember walking into, , an Arby's, like, 10 years later, so early 2000s, and they were advertising their Atkins diet. <Laugh> You know, so it, it took that long for, , that it to get into the mainstream. But this is going mainstream. , And so what are we gonna be talking about a year from now? , I think we'll be discussing the Bridge Program's raging success and your new wardrobe after you drop 30 pounds. <Laugh>

Burda:

I hope you're right, Dave. I hope you're right. , Great analysis. Thank you. , Juli, any questions for Dave?

Murchinson:

I'm excited for the weekly check-in, Burda, that's for sure.

Johnson:

Yeah.

Murchinson:

Dave, I was just discussing this, as I said, with a bunch of women last night in healthcare. And many of them are convinced that the clinical benefits are just too good. Like, I talked to a handful of women who actually really just wanna go on them for the clinical benefits. They actually don't really need the weight loss. And the question is, how do you think about dosing for that? Like, why are, why are we ma - deciding that? But, , they think that we're gonna be on these largely for life, like people are on statins. Do you agree with that? And how long do you give it until that is more the reality?

Johnson:

Yeah, I think that's entirely possible, Julie. I just had my annual physical with my one medical doctor and he said there's a whole slew of new research reports talking about the beneficial effects of statins above and beyond the reducing cholesterol, , going to lower inflammation and so on. So it, it's, it's interesting as we learn more and more about how these drugs work, they often become better and better. You know, when I think about the GLP-1 drugs and how they work, you know, pretty much everything we see, think and feel about the world results from electronic signaling inside our brain. And the fact that these drugs can go into the brain, which is a dark space, right? And, reduce appetite, and probably other addictive behaviors. And I'm also hearing that the reason they work as well as they do and are as broadly beneficial as they do is they, they reduce inflammation. And if that's the case, , that has, has broad potential benefits for population health. You know, it's almost ironic in a

way, because what the food companies figured out was how to process food, you know, sugar, fat, and salt in exactly the right amounts to over, , overcome the brain's natural resistance to overeating, which has been a big part of the reason that we have the obesity crisis as a country. And now we have a drug that seems to counteract that and, , you know,<laugh> people, you know, they've done these,, followed, , GLP-1 users into the grocery store and they're, you know, they're, they're buying kale. , So I, I do think we're only at the beginning of this. I think over time, the drugs are gona get better and they really could become part of the daily regimen for tens of millions of people, , this country and even more around the world.

Burda:

Interesting. My old primary care physician, he thought we should put statins in the water supply like fluoride. And I said, "That's interesting, but I wouldn't repeat that to many people because, - <laugh> That's, you might get arrested. But, yeah, he saw the benefits and, he thought people should have them even without knowing they were getting them. So interesting. Thanks, Dave. , Juli, you were the first one to bring up GLP-1s on this show years ago. And, , you brought up the bridge program two weeks ago, so you're obviously all over this. , What are the market implications, good and bad, and what are we talking about a year from now?

Murchinson:

Well, first, there is so much good, to Dave's point. , There's a little bad that I think, but, you know, CMS just did something that no commercial payer has been willing to do and they set a price anchor at the 245 net, Dave, and the 50 to patient. Like, that's not some sort of rebate gain. They negotiated a floor. So, , I don't know if that's good or bad, but it feels like a, a first in many ways.

Johnson:

Feels good to me. Yeah. Feels good to me. Transparency.

Murchinson:

<Laugh> Yeah. And, you know, affordability. And if the bridge data shows better adherence and downstream savings, those numbers are gonna become the reference point that every PBM and employer benchmarks against, right? So there's the data potential here and the market kind of setting intelligence, , is probably, like, the first time we'll have something at this scale. So I think that's exciting. So this is, that's the upside, you know, health economics that I think people should be watching and not just the coverage headline, which of course is gonna get all the fanfare. There is bad here, though, around capacity, not necessarily politics. That Med City News article, you know, flagged it pretty bluntly said that pharmacies don't necessarily know at the point of sale whether a script goes through Bridge or their Part D, Dave. That's what I read it. And there's no formal appeals process for denials, and the supply chain is already a mess. So, you know, I feel like this is how they can make millions of people eligible overnight when we're already in a strained kind of confusing system. It's, it's not great. And layer onto that Burna's new sleep apnea coverage, right? Like, we are accelerating the number of eligible people in a program that's, you know, it's kind of operationally improvising what it's doing here. So it's almost like it's a pilot that's, like, immediately running at scale. And I think just as someone who's been around a lot of pilots, that's bad. And the other bad thing I think is, , you know, if I read this right, the program only works, the beneficiary already has Part D. Is that the way you read it, Dave?

Burda:

That's, yeah, I think that was - Yeah. And you, you can only get it if your Part D plan doesn't cover it.

Murchinson:

Yeah. So - I think. , Yeah. So, I'm glad we read it the right way, because I feel like the Part D thing is, it's confusing and it's also, like, a barrier, right? And anyone outside of that lane, you know, obviously, William Prescriber. Anyone outside of that lane, , is still funneling to the direct-to-consumer or telehealth market. So it's not a perfect program in terms of how people take advantage of it, but they did, you know, they built this safer way of getting access than the consumer, you know, direct to consumer. So, , I'm not so sure that it's, you know, it makes sense the way they built it to your average Medicare beneficiary, but maybe it does. So a year from now, , I think I bet on three things. One is that enrollment is lower than they think it's gonna be. I just think it's gonna be…

Johnson:
Oh, interesting. Okay. We're, we're, we're opposite on that. Okay. Dave, make a note a year from now to see who was right and who was wrong. <Laugh>

Murchinson:

It's totally, that'll be a fun game, actually. <Laugh> And I have a hard time saying this because I actually feel like, why wouldn't we take advantage of this, right? But I think it'll be hard for a lot of people to actually, like, just make it happen. So we'll see how that goes. Two, I think the data that comes out of this, the adherence data I was talking about, the outcomes data, , it's gonna be fascinating to watch. Like, I think that's gonna become the entire argument, hopefully. But I think I'm being a litle Pollyanna in that way because I think actually, , still be stuck in, like, the politics of whether this is being covered and how it's being covered and who's adopting. But I'd love to think that the outcomes data is gonna be a factor. Three, I think this operational friction that I talked about, , , I think that it will become a case study for why the government has a very hard time getting involved in a market that's really already hot. I just, I don't see these things being fixed easily.

, Certainly I think the supply chain's gonna get worse. So, , it just feels to me like that's a, it's a losing battle for the government.

Burda:

Interesting. I think my wife's KPI is whether I get rid of my CPAP machine, right?

Murchinson:

As it should be.

Burda:

Yeah, as it should be, right? <Laugh> Thanks, Julie. , Dave, any questions for Julie? <Laugh>

Johnson:

Well, I think the supply demand discussion's pretty fascinating. When I was a Peace Corps volunteer in, in Liberia, the roads washed out every rainy season. And somehow, some way they managed to figure out the local merchants, how to get club beer into town because people wanted it so much. I just, I guess, feel the supply issues under the weight of this enormous demand will, will figure themselves out. But I might be Pollyannish on that. So Julie, great points. Anyway, Julie, Berta referenced the secret shopper research study that published this month in JAMA that demonstrated it's relatively easy to arrange for a GLP-1 prescription without clinician involvement. How worried should we be about the marketplace creating mechanisms outside the medical establishment for consumers to get access to these drugs? In fact, should we, should we be worried at all?

Murchinson:

Yeah. I mean, this is kind of fascinating. The real worry isn't that access is easy. It's like how they're selecting these people that they barely know

off a questionnaire in under five minutes. And I mean, a lot of those people don't require any clinician contact at all, right? So -

Johnson:
Yeah.

Murchinson:
It's like they're treating GLP-1s like, do you want the red gummy bears or the green? <Laugh> So I don't know, dosing errors and God, we all know the contraindication risk of all the DC platforms anyway. And, you know, unmodern titration, it's, you know, I think the risk is real there. But honestly, these platforms are there for a reason, right? They don't... People don't want the doctor's office to be slow and expensive and say no. They just wanna go around it. And if a quarter of employers are actively steering their workers towards these platforms, like, that's a big deal, right? They're rounding people around the doctor to get their employees what they want. And what does that mean? It means that, like, there's the risk to all the, , clinical benefits I just mentioned and lower cost and just not really putting the clinical, you know, the clinical piece of this first. So I do worry, but I do think there's probably a, a regulatory fix for this and not the scarcity play that's happening. I don't know. It seems, it seems easy to fix, but maybe that's Pollyannish of me to use our word for the day.

Burda:
Yeah. Yeah. Well, I'm in the unique position of being the guinea pig for this topic. So, I'm like George Plimpton in Paper Lion, right? I hope I don't get the wind knocked out of me at the end. You remember that?

Johnson:
You're dating yourself now, man.

Burda:

I am. <Laugh> I am. So we'll, we'll see what happens. So, , wish me luck. All right. Thanks, Dave. And thank you, Juli. That was, that was great. , Now let's talk about other big healthcare news that happened this week. Julie, , what else happened that we should know about?

Murchinson:

Well, you may have seen, , that CMS's 2027 Physician Fee Schedule, , came out and there's something in there about the RPM vendors that bundles codes that doesn't seem great for the RPM vendor business model. So if you haven't noticed that, I've seen a bunch on it this week.

Burda:

I saw that. Yeah. Remote patient monitoring. , And we were just talking about that last week as being one of the salvations for rural care. Yes. So how do you, , reconcile both those positions? Interesting. Dave, what's your big healthcare news of the week?

Johnson:

Well, , another earthquake announcement out of, ,Verona, Wisconsin. Same, same as last week's. <Laugh> , , yesterday news broke, , through Chrissy Farr's second opinion. And I'd heard it even before that, that, , , Seth Hein, , was head of products and strategy at Epic is also leaving, , the company. This comes on the heels of the announcement of Sumit Rana leaving. And Seth was another one of the people inside of Epic who I think was on the pro-interoperability side of things. So it feels like the evidence is mounting that, Epic is choosing to, to fight rather than switch, right? Gonna be watching that pretty carefully.

Burda:

Yeah. That's a real, real signal. Thanks, Dave. And thank you, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the Roundup on Spotify,

Apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.