Research @ Citi Podcast Episode 56: Thankful for Health — AI, Vaccines, and Weight Loss

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Transcript:

Anne Malone (0:00)

Hi everyone. Welcome to the Research @ Citi podcast. I'm Anne Malone, the North America Head of Equity Research at Citi. With me today on the podcast is Geoff Meacham, our lead biotech and pharma analyst and Global Head of Healthcare here at Citi. Today we're going to have Geoff provide his views on where we stand post-3Q earnings in a world where the measuring stick is the promise of artificial intelligence. Geoff, always a pleasure to talk healthcare with you — or anything with you.

So it seems an aspect of investing in healthcare these days means competing against AI in terms of growth and product pipeline. Do you believe that? And what did the third-quarter results tell you?

Geoff Meacham (0:40)

So the third quarter, first of all, the emphasis on AI was a consistent part of a lot of the questions. I don't know if we got a lot of answers on 3Q, but obviously companies have their boilerplate answer on what it could mean going forward.

Just based on my industry background and how long I've followed this sector, I do feel like the applications within AI are probably pretty similar to what we've had over the past couple of years: speeding up drug development, maybe finding newer targets that otherwise weren't there, obviously sell more drugs on the commercial side. But I do feel like a lot of the things on the drug-development continuum will take some time — like three to five years.

So although there's heavy investment today, the report card is probably in a 2028 to 2030 timeframe.

Anne Malone (1:44)

But are these stocks able to grow enough with enough product pipeline to get either specialist investors or the generalist investor involved and take some money back from the TMT side of things?

Geoff Meacham (1:56)

Over the past year or so, it's pretty much just been Lilly as the fastest growing mega-cap in the biopharma sector, at least in the U.S. And that's the only one I think that generalists have been able to at least focus on. It's just a tough comp, right? When a lot of TMT companies are growing top line 20% plus, 50% plus, that's essentially the only one. There hasn't really been a lot of interest in the value stocks or single-digit-multiples, the fixer-uppers.

So, growing let's call it mid-to-high single-digit like the engines of the world or AbbVie, Gilead, maybe Regeneron, but not broad interest in the space. I think definitely it's been pretty much Lilly in the backdrop of TMT, as you said.

Anne Malone (2:56)

What can change that? Can the climate change it? Is it more reassurance on tariffs or the FDA or the product pipeline? Where can we go from here?

Geoff Meacham (1:56)

I do feel like the risk profile has definitely gotten better just in the past month or so. If you look at the Pfizer announcement, for example, with the Trump administration, there have been a couple of other pharmas as well that have talked about MFN agreements and a promise to onshore manufacturing. I think everyone expects that to be the case going forward, that you'll have formal agreements. And so I think the headline risk of tariffs or of dramatic cuts to drug price is diminished. So that's going to, I think, be a big part of the generalist and broader appeal to the therapeutic space.

And then the rest of it is just the pipeline, right? I mean, there are a lot of really, really exciting assets that are going to come out that are disruptive, that are big diseases. So just to name a couple; non-opioid pain drugs, novel mechanisms, curative intent, cell therapies, not just for cancers, but also for autoimmune diseases. Obviously GLP-1s, but GLP-1s not just in diabetes, obesity, but looking at neuro-psych indications or inflammation or cardiac indications. So, there's a lot of really exciting stuff. And I think 2026 is going to be a big year for that.

Anne Malone (4:22)

So, some, let's call it life-saving, life-changing drugs. This is a good time to double back on pricing and payers. So how do we pay for that innovation? How do we deal with pricing pressures?

Geoff Meacham (4:35)

You know, what's interesting is that some of the previous agreements with the Trump administration, they're mostly on the Medicaid book of business — which by the way, in a lot of cases it's a tiny fraction of U.S. biopharma. The issue for the most part there is just the fact that you have a situation where you can concede a heavier discount on a

tiny portion of the business. But to your point, though, overall I think the bigger picture on pricing is to try to get rid of the middleman.

So is there going to be PBM reform? TrumpRx is sort of the in-house PBM, at least that's the plans for it, based on some of the prior announcements. And I think the other piece of it is just to get OUS countries, governments around the world, entities around the world to just pay more for the innovations that we're getting in the U.S. So that's going to take time. But I do think that the trend is going to be nominally down, even on some of these newer therapies.

Anne Malone (5:36)

Down on pricing pressure on them.

Geoff Meacham (5:37)

Correct.

Anne Malone (5:39)

So if I have pricing pressure, and I'm expected to bring manufacturing — and, right, spend a fortune to build manufacturing — does that say anything about what we can expect on profitability or margins? Or no?

Geoff Meacham (5:53)

I think the pharma business model and big-cap biotech business model, these are very profitable companies — in some cases 40%, 50% off margins, they can stomach a lot of pressure on the pricing side of things. So, I wouldn't expect margins to really be affected that much. I think the biggest drag on margins is really when you have patent expirations, and for sure that that does affect some of the single-digit-multiple stocks in the space. Most of them are past them. And some of the bigger ones are, I'd say, behind us, except from a couple of companies.

Anne Malone (6:29)

OK. Likely other hot-button topic these days is vaccines. What's the future there, especially under this administration?

Geoff Meacham (6:38)

That was probably the bigger clear negative with the main source of uncertainty on the sector to start the year. I think it's just a mandate coming from the Trump administration and Bobby Kennedy as head of HHS, to not have a top-down strategy, right? Where you have a mandate coming from government to vaccinate things like kids, right?

The whole spirit of the change at CDC and FDA is just to say, “Look, have the conversations between a parent and their kids, or a physician and their family” and not have a top-down mandate. And so that's probably going to be the trend going forward.

So I don't expect that to really open up at all. Maybe for the next administration you could see a shift in vaccine.

Anne Malone (7:28)

Amazing how that's turned. With that, tariffs seem in a better place. We're going to bring manufacturing back. We kind of know where everything stands. Does that mean we're on stable enough ground for a) a wave of M&A; and b) is that enough to get a banking cycle started? Which we've been waiting for, for quite some time.

Geoff Meacham (7:50)

So this first part of 2026 will be the five-year anniversary of the nuclear winter for SMID caps.

Anne Malone (7:57)

I can't believe it's already been five years!

Geoff Meacham (8:00)

I know! But I would say that if you start with SMIDs, I do feel like there is meaningfully more interest now, and in the past two months or so, than really in any time since 2021. So that's a good thing. We haven't seen an IPO wave, at least not yet, but there's a ton of companies that are ready to be queued up for the JPM conference in early January. And then the companies that have had either data or drug approvals or some de-risking event where stocks move and then companies raise equity, that typically is oversubscribed.

And so you do see a functioning market for the SMIDs that have had a win. So that's a good thing. And the entire past couple of years has been a backdrop of pretty, pretty decent M&A volume, right? I mean, a lot of institutional investors are just really tired of hearing pharmas and big-cap biotechs just do buybacks and dividend hikes, etc. So they've been rewarded for doing deals, right?

And so you see a ton of $5 to $10 to maybe max $15 billion-dollar deals. That's probably going to continue going forward. That may even go up because there are some exciting innovations that I think pharma will want to tuck in here. So that backdrop of having that happen in the background is definitely a net positive for SMID biotech, all of which I think bodes well for a good ’26, ’27.

Anne Malone (9:34)

Going to get interesting again. Outside of pharma and biotech, you work closely with Patrick [Donnelly] and Joanne [Wuensch], our tools and medtech analysts, respectively. Did their stocks and their sectors fare much differently than yours in the recent earnings season?

Geoff Meacham (9:51)

From talking to Joanne on the medical-device end of things, the companies that were expected to do well and have better fundamentals, better growth, those were rewarded for sure. So it's a little bit of the same in big-cap therapeutics where the higher-multiple stocks continue. You have winners and losers, right? But the winners keep winning and the losers remain challenged.

On the tools side of things, with respect to Patrick's space, for the most part I think there's broad optimism. There is still, maybe for this year, a little bit more of a shoe to drop on numbers going down. But I would say on the back of some of these pharma agreements with the Trump administration and onshoring, there's a ton more optimism looking to 2026.

We need all the picks and shovels and all the investments in manufacturing and R&D, really. And so that hasn't really been a good backdrop over the past couple of years, but in ’26, I think that's going to definitely take a directional leg up.

Anne Malone (10:55)

Probably a good time for me to mention our Global Healthcare Conference is having its second year in Miami, Dec. 2 and 3. Good chance to speak to all of these companies before they close their books for the year.

It seems that this would be a good time to talk about the update on GLPs. They've been such a driver for so long. What's next? How big is the next leg of innovation there and the broadening?

Geoff Meacham (11:27)

So it's still the number one hot topic when I meet with investors. It's gone from say 70% to maybe 50%, it's still a big part of the conversation. It's just because you see such massive volume growth. And to give you an example, it's been mostly a U.S. phenom in the obesity rollout, but just in the past couple of quarters, Lily, for example, has rolled out Mounjaro for obesity in Europe, and that's getting amazing traction.

We're still in the commercial battleground between Novo and Lilly from a market-share perspective in diabetes, obesity, and to some degree, sleep apnea.

Now, the ’26 dynamic is a little different. That should bring the oral drug called Orforglipron from Lilly. And it's super unusual in that there's not been an oral that's been

this effective. It's about 10% weight loss. It's about 10% discontinuation rates. Pretty clean safety profile.

Anne Malone (12:36)

What are those numbers for injections, if you can remind us?

Geoff Meacham (12:40)

For injections it's about double that on the efficacy. So you can get to 15% or max 20% weight loss. The discontinuation rates are very good, are mid-single digits for both Novo and for Lilly. But it's a weekly injection, right? So I still think steady-state orals are maybe a slight bias to the overall market, like talking about five years from now call it 60-40 in favor of orals.

But it's a different commercial dynamic in that the oral drugs, I think, will be mostly for overweight, not obese patients. So these are patients that are probably not going to get reimbursed. If they do, they have some comorbidity, cardiovascular disease, etc. So there's going to be, I think, a much bigger consumer angle here, a cash pay kind of system.

And there's been some chatter over the past few days about an agreement between these companies and the Trump administration about lowering the monthly cost to something in the 150-, maybe 250-buck range. That would definitely drive volume pretty massively. And this is a situation where you could see pockets of pretty broad use that could maybe, in aggregate, compete with the U.S. So Latin America, Europe, maybe Asia. And that is, I think, something to watch for sure.

The consumer angle, though Anne, I'd say is new to the space. We've only had Botox before in the case of AbbVie. There really hasn't been a consumer-centric business model for any of the biopharmas. And so this is definitely the biggest drug and the most impactful thus far.

Anne Malone (14:22)

$150 to $200 a month, that gets you lifestyle choices, affordability, at least in the U.S., right? I mean, that's probably my Diet Coke budget for the month. So, that's a real game changer, and the orals come early ’26?

Geoff Meacham (14:39)

There was some chatter about using a new FDA approval path that could bring it in December, but my sense is that it's a pretty broad application with tons of patients. It'll be sometime I suspect in 1Q, worst case like early 2Q.

Anne Malone (14:55)

And it's market expansion? It's not market cannibalization?

Geoff Meacham (15:01)

I think there will be some cannibalization of patients. I'm talking to Lilly, there's about 40% of the people on Zepbound, the obesity drug that's injected, that are out of pocket, like cash pay. So, those patients will probably shift to an oral.

The other piece though, Anne, is — and we don't have the data yet, could come in the first quarter — the maintenance piece. So they don't have Phase 3 data, but the idea is that if a patient who's otherwise obese and loses 20% of their weight, you don't go from that to nothing, right? You still have to stay on a drug. And the idea is that you could switch to a daily oral, which would be a little bit more convenient than a weekly injectable.

So, that'll be interesting how that plays out. But that is a one-element persistent use. I wouldn't expect, though, the bulk of people going on this oral drug for weight loss to be on that long — three months, six months, lose a few pounds ahead of a wedding or a beach trip, and then you're off and then you go back on. You gain it back six months later, right? But the amazing thing is that the drugs work at the end of the day. That's what matters.

Anne Malone (16:13)

No, life is good, amazing to have that sort of control over it. Geoff, I always like talking to you on all of these topics. Always interesting!

This podcast was recorded on Nov. 5, 2025. Be sure to join us for our next Research @ Citi podcast. Feel free to explore our previous podcasts, all of which are available on this channel and other channels as well. Click to subscribe to make sure you don't miss an episode. Thanks so much, everyone.

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