Portfolio Manager Comment on the Outlook for the Biotech Sector and the Potential Implications of Drug Pricing

Dear Investors,

In this note we outline our positive outlook for bio-pharma and life sciences and offer our specific views about the drug pricing debate.

Summary & Outlook

- The last year has seen significant volatility and many questions about the future of the bio-pharma and life sciences sectors. Concerns around the FDA, tariffs, pricing, vaccines and NIH funding came all at once, an unprecedented situation.
- We believe that certainty on drug pricing and tariffs is likely within the next 6 months as a negotiated agreement between the industry and Pres. Trump, giving Trump a "win" for the 2026 mid-terms.
- A thoughtful solution to drug pricing where Europe pays more, and the US less, could bring significant long-term certainty and raise valuation multiples materially. The market believes this outcome is highly unlikely, but we think that could be the wrong view.
- We believe US NIH funding for FY26 is also likely to be better than expected, boosting sentiment for Life Sciences.

Our investment philosophy is underpinned by four key beliefs:

1. The biotechnology industry and American leadership in medical innovation is not something the US Administration/Congress want to destroy, especially with an ever-improving China.
2. Great drugs will be approved and prescribed.
3. The resulting sales and rising earnings will lead to rising stock prices over time.
4. Precision medicine is a multi-decade trend that can improve the odds of success and bring benefits for patients, industry and society.

To capture this value and growth our portfolio is focused on the developers and enablers of precision medicine and seeks to balance attractive returns and risk by having 60-70% of the AUM in revenue generating companies and 40-50% in GAAP profitable companies.

We expect the gradual resolution of these issues will firmly put biotech, pharma and life sciences back on investors' radar and bring capital flowing back to the sector.

On a personal note, I added to my holdings in the BlueBox Precision Medicine fund during early 2Q25.

Upcoming news items we are watching:

NIH budgets for FY26 – We expect approximately flat vs FY25. A positive scenario for the Life Sciences sector vs current market expectations and the original budget (-40% y/y).

Drug pricing negotiations – We suspect a negotiated agreement will be reached in time for the mid-terms in 2026, probably in the next 6m or so. It is unlikely to be a disaster, as many investors fear and may well bring greater long-term certainty.

Drug tariffs - The bio-pharma industry has committed to more than $300bn of investments in the US over the next decade, when combined with a drug pricing deal this should reduce the threat from tariffs.

BIOSECURE Act - Likely back into focus during 4Q25 and into 2026, which may have upside for some of our enablers.

Drug Pricing

In this section we delve deeper into the topic of drug pricing and focus the potential outcomes. As drug pricing is complex, we provide some further details on the market and overall system in the appendix**.**

Setting the Scene

The debate about drug pricing has been especially prominent in the last decade, since Hillary Clinton re-ignited it during her 2016 campaign.

While it is easy and popular to bash the drug industry, it is equally easy to bash the insurance industry/ middlemen in the US and the reimbursement agencies in Europe. There are a number of issues on all sides of the pricing debate that are often ignored or mis-understood. For this note, we focus on the key issues and potential outcomes only.

President Trump's May 12 Executive Order seeks to bring most favoured nation (MFN) pricing to pharmaceuticals in the US. In theory, that means the price would come down to the lowest of the countries with a GDP per capita of 60% of the United States. At the same time, he would like European countries to pay more so the global impact to the companies is limited. He also wants US companies to invest in manufacturing and research in the US. All of which is sprinkled with the threat of tariffs.

The US pharmaceutical market can be divided up by the ultimate payer and into retail prescriptions and out-patient physician administered drugs (e.g. intravenous oncology drugs).

In general, the pharmaceutical market has a list 'sticker' price and a series of complex rebates/discounts that bring the net realised price by drug companies to c.50% of the list price. The rebates and discounts accrue to pharmacy benefit managers (PBMs), hospitals and the eventual payer (Government/ employers).

Total pharmaceuticals spend is 10-14% of US healthcare expenditure, broken down as follows (based on 2023 figures):

Category	$bn	% total	Notes
Commercial	175	26%	Private employers
Medicare Part D	145	21%	Retail prescriptions for >65's
Medicaid	51	8%	Low income
Veterans Affairs	9	1%	Former Servicemen/women
Out of Pocket / Other	70	10%	Private individuals
Total Retail	**450**	66%	
Medicare Part B	51	8%	Physician administered drugs for >65's
Other non-retail	178	26%	Physician administered drugs not in Medicare
Total Pharmaceuticals	**679**	100%	
of which is 340B:	66	10%	Institutions eligible to buy at discounted prices

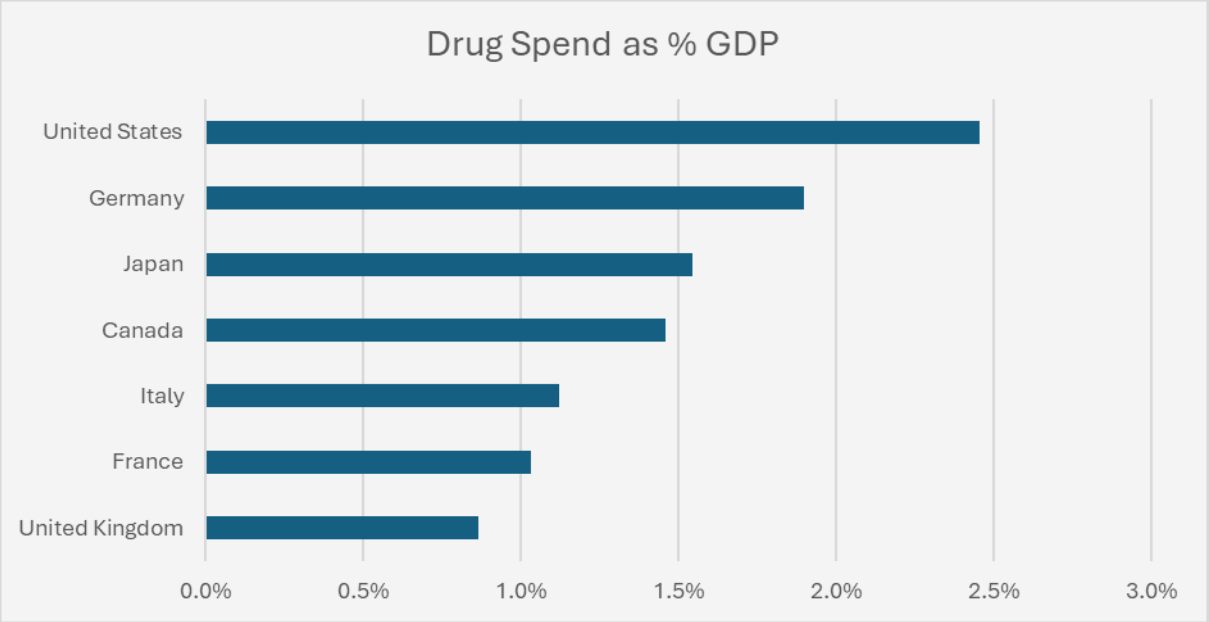
Source: CMS.gov, Altarum, Drug Channels Institute

Key Issues to Solve

We believe there are six key issues at play politically:

1. The pharmaceutical industry is rarely seen favourably by the public so is an easy target.
2. Healthcare is 18% of GDP in the US, although drugs are only ~10% of this.
3. High out of pocket costs that voters feel monthly (usually based on list prices, not net price). Although this was partly addressed by the Inflation Reduction Act for Medicare Part D.
4. Pres. Trump likely wants a "win" for the mid-term elections in 2026.
5. The pharma industry wants both PBM and 340B program reforms.
6. Akin to defence spending, Pres. Trump feels that ex-US countries are underpaying, and the US is overpaying.

This final point is controversial, but when you consider the massive investment the US makes in basic science (NIH budget of $48bn p.a.), the US is >65% of global pharma profits, several European countries cap total drug spend growth through industry level rebates and use outdated metrics/thresholds in assessing the value of medicines, it is not an unreasonable position. The chart below clearly shows that the UK and EU countries spend less as a percentage of GDP vs America on pharmaceuticals.



Sources: CMS.gov, IQVIA, Altarum, CIHI drug spending, NHS, ESIP, destatis. NB some of these estimates may not include additional country level rebates.

Getting to a Solution

The topic is very difficult to solve. There are many parts of the system that are paid based on the price of a drug and the risk of unintended consequences is high. Furthermore, the route to implementation of major changes requires either Congressional approval (unlikely) or a specific pilot program via the CMS that has strict conditions related to it.

We believe the US administration knows this, so the Executive Order, subsequent press release from HHS and July 31 letters from Pres. Trump invite the industry to negotiate a solution.

Pres. Trump's letters to the industry outline his wish list, which we assume is a best case, with a deadline for renewed proposals of September 30 2025. In brief these wishes are:

- MFN pricing in Medicaid.
- MFN pricing for newly launched drugs in Medicare, Medicaid and commercial markets.
- Return increased revenue abroad to American patients and taxpayers.
- Provide for direct to consumer purchasing at MFN pricing.

Our view on these is as follows:

Direct to consumer access to drugs is already being implemented for some drugs at or close to net prices. The industry supports this, but it is a small share of the market.

Medicaid already has the lowest net price due to mandatory rebates and inflation penalties. Medicaid is around 10% of drug spend, so further discounts here wouldn't be a huge issue (with company dependent exposure).

Newly launched drugs - MFN pricing for newly launched drugs in all three channels is an idea that some CEO's have expressed support for. However, it only works if there is a co-ordinated response across key ex-US countries. A route for this to happen could be:

- Agree MFN pricing in the US for newly launched drugs, based on wealthier countries e.g. the G7, adjusting for GDP.
- The selected ex-US nations agree to increase the value applied to drugs in reimbursement/value assessments for newly launched medicines with clarity on the process. This provides a route to increase value steadily over 10-15 years.
- The excess rebate schemes in place in European countries that cap industry growth can be removed or reduced for newly launched drugs, keeping existing rebates for the current drugs but not new ones.
- This could be achieved with the threat of major tariffs on pharmaceutical manufacturing e.g. for the EU on Ireland.
- This solution could be a way to remove the pricing debate for many years. It could bring significant stability and value to the system, investors and the industry, while enabling investment both in the US and ex-US.
- Politically this solution would be a major win for Pres. Trump, achieving something previously unthinkable, while removing Democratic campaign point.

Crucially, with the 2026 mid-terms approaching and a September deadline near-term, we may get some clarity on this issue late 2025/early 2026. If the result is a more balanced global system with greater certainty the multiple that is applied to the sector may go up considerably.

For our portfolio, we would not be concerned by any of these outcomes. Most of our commercial companies (40% of portfolio) have prices that are similar between US and Europe, due to the rare disease status or being recently launched. Medicaid exposure is broadly manageable and certainty over ex-US pricing could be a long-term benefit.

Mark Dainty, 18.09.2025
Lead Portfolio Manager of the BlueBox Precision Medicine Fund

Appendix

Here we lay out several key facts about the landscape for pharmaceutical pricing in the US and Europe. This is to provide a resource of key information for those less familiar with the intricacies of the system.

- In the US drugs have a list price and a net price. The list price can be considered the "sticker price", the net price is the actual price recorded as revenue by the drug company after a number of mandatory and negotiated fees/rebates/discounts. Net price is on average ~50% off the list price.
- In the US these fees/rebates/discounts accrue to insurance companies and pharmacy benefit managers (entities that negotiate and administer formulary lists/reimbursement and operate mail-order pharmacies), hospitals and wholesalers. Most rebates are passed through to the ultimate payer (employers/government), while discounts received by hospitals and fees charged by middlemen are banked as profit. It also includes free drug or co-pay assistance programs where patients directly benefit.
- A similar dynamic occurs in European countries where a list price is discounted (sometimes confidentially) to get reimbursement in the country. While prices in Europe are lower, the negotiation process takes 1-2 years longer. However, there is a large volume uplift as it brings universal access to all patients.
- Several European countries also apply additional rebates to the whole industry if drug spend grows above a certain threshold each year. These can be in the order 10-25% on top of the agreed discount to get reimbursement. This practice is essentially a way of capping aggregate drug spending. Over-spend is not due to price increases but due to higher utilisation of drugs.
- US patients often pay an out-of-pocket co-payment upon receipt of a drug. This is driven by the insurance plan and often reflects list prices, not the net price. Essentially this is a way for payers to shift cost burden on to the patient, in return for lower premiums. The net result of this is that prescriptions are often abandoned at the pharmacy counter and adherence is lower, leading to worse health outcomes.
- In the US, hospitals and clinics are reimbursed for administering drugs at a rate based on the average selling price + a percentage. The same institution can be paid different amounts for the same drug or procedure depending on whether the patient is in commercial, Medicaid or Medicare.
- Hospitals in poorer areas can access the 340B program, enabling them to buy drugs at a heavily discounted Medicaid rate in order to make extra profit by receiving payment at a full rate. This program has ballooned over the last decade as hospital systems have expanded their networks often to less poor areas, it now totals $66bn, from $6bn in 2010. There is a series of efforts ongoing in Congress to reform the 340B program.
- Over the last decade the insurance companies, wholesalers and pharmacy benefit managers have merged such that >80% of the market is served by three large companies. PBM reform is likely to come to Congress at some point, with the aim to increase transparency, reduce costs and potentially reduce the gross to net adjustment for drugs.
- The implementation of major changes in Government reimbursement programs usually requires either Congressional approval (unlikely the Democrats would approve a Trump win) or a limited pilot program that must meet several conditions, including no harm to access or care standards, as well as survive any court challenges. All of which makes the path to implementation for drastic changes very difficult.

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