**Bernstein Strategic Decisions Conference** ***(Corrected version)***

## Event Details

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Company: CVS Health Corp.
Ticker: CVS-US

## Company Participants

Shawn M. Guertin - CVS Health Corp., Chief Financial Officer & Executive Vice President

## Other Participants

Lance Wilkes - Analyst

# MANAGEMENT DISCUSSION SECTION

**Lance Wilkes**

Okay. Looks like we're ready to go and mic's on and everything like that. Welcome, everybody. I'm Lance Wilkes, healthcare services analyst for Bernstein, and the pleasure of having a fireside chat here with CVS Health. And so, I'm going to let Shawn introduce himself in a moment. But just any logistics, I think we have Pigeonhole, which is open here somewhere, and so you can submit questions that way. We'll go through kind of a planned fireside chat of questions as well, and then, obviously, we got meetings for the rest of the day.

So, with that, Shawn, why don't you go ahead and introduce yourself and the company just a little bit, and then I'll start taking you through some of the questions.

**Shawn M. Guertin**

Great. I'm Shawn Guertin. I'm the CFO at CVS Health; have been back at CVS Health. A couple of years before that, I was the CFO at Aetna up to the time of the merger. So, I've seen lots of different parts of this company over time. So, today I'll just – one housekeeping detail, I will obviously be making forward-looking statements based on projections from time to time, and so I would have you recognize that those may be wrong. And I direct your attention to our most recent SEC filings, 10-K and 10-Q, which contain a complete description of our risk factors.

# QUESTION AND ANSWER SECTION

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**Analyst:**Lance Wilkes

**Question – Lance Wilkes:** Great. Well, I think CVS – I was just saying this as you were coming on the stage. I think CVS is, in my opinion and having just been out I mean with investors the last few weeks, maybe the most interesting and controversial name in my coverage right now. And a lot of that has to do with the combination of factors in the company, as well as the long-term transformation you're undergoing.

So, let me just take you through kind of a series of questions here and start off with sort of the framing of the vision of the company. So, could you just frame the long-term vision for CVS? What do you expect it to look like 5 to 10 years from now? And then, we can talk a little bit about proportion of earnings from those different segments and things like that.

**Answer – Shawn M. Guertin:** Yeah. No, that's a great place to start, because what we really have, there's sort of a strategic level of that question and sort of a tactical level of that question. And what I would say, tactically, the challenge for CVS in the past has been we have three major business lines. Two of those business lines, the Health Care Benefits business and what we used to call the Pharmacy Services segment, they have, depending on the



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year (00:02:55), kind of core earnings growth assumption from the mid-single digits into the high-single digits. And then on our retail operation, that has been flattish over time.

So, the tactical challenge is how to create better earnings growth sort of from that profile of businesses. And that led us to think a lot about a lot of different alternatives. But what we began to realize is that there was an opportunity here that was somewhat unique to us to play on a really powerful trend in health care, which is value-based care, and the move to value-based care from fee-for-service; the trend of the role of the consumer in health care, which only got accelerated by the pandemic; and some other very powerful trends, like moving care away from acute inpatient into home settings, as an example.

All of those things led us to begin to see the opportunity that existed in basically building a health care delivery business, but one that wasn't focused on fee-for-service; one that was really focused on capitalizing on value-based care. And I think this is really essential when we think about sort of the economics to providers and customers.

And the one statistic that I – or comment that I throw out to people a lot is when we talk about value-based care, we tend to think about Medicare Advantage because it's the most mature. But two successive presidential administrations through CMMI and CMS have said it's their goal to get all of Medicare into some form of value-based arrangement by 2030. That's a huge opportunity potentially to be prepared for.

So, the idea is to have a health care delivery division that really plays to the strength of the consumer and our ability to engage the consumer, really has top tier capabilities in value-based care. And we think that building that division can add 1% to 2% to our growth rate over time as a company, going back to where I started sort of tactically.

And when you look at Oak and Signify by themselves – and we'll see this again when I talk a little bit about 2024 at some point, we think Oak and Signify by themselves can do at least 1% of that 1% to 2%. And we're beginning to lay that groundwork to create that earnings capacity. If you want we really (00:05:17) supplement, you could think about it as either building a fourth business or fleshing out one of those – the third business, which is the way we're organized and really doing that with a business that has better growth characteristics.

The other really important thing about this that we've subjected every asset that we have looked at to this test is can we make them better and do they make us better and sort of create the sort of two-way synergy dynamic. There's a lot of different things we could have done that have different growth characteristics, but this sort of angle around home care, value-based primary care, physician enablement to move to value-based care, we think that's one of these things that actually makes our payer business better and that our other assets can really add and differentiate the experience.

**Question – Lance Wilkes:** That's really interesting. Now, to bring that to kind of the tactical right now, I think there's a lot of discussion around your targets for 2024 and 2025, the $9 and the $10. Can you talk a little bit about both kind of the important drivers there, but maybe the headwinds and tailwinds associated with those?

**Answer – Shawn M. Guertin:** Yeah. And to your point about people – the questions that people ask us about, there is a lot going on. And there's a lot going on operationally. There's a lot going on in the environment. There's a lot of regulatory activity. So, there certainly is a lot of moving pieces right now.

One of the things that the – some of the bigger headwinds we have going into 2024 are on the Health Care Benefits Business, the loss of our four-star position for 2024. We've talked about that for a while – we've known about that for a while. We've mitigated a good chunk of that, but it's still going to have a pretty significant hit.

We're losing a PBM contract. And most recently on our earnings call, we've adjusted a little bit. There's been some changes in the 340B marketplace for the PBM. And we're seeing a little bit of a quicker decline in some of the COVID contribution. When we look at all that, when we start thinking about how do we go from 2023 to 2024, I think it all starts when we look at our businesses. We think our adjusted operating income – excluding Oak and Signify for a second, our adjusted operating income could be flat even with all those headwinds.

And a couple of levers that people miss when they try to do that math and think about that is we have some opportunities in the business. I'd say there's really three. One we've talked about a lot. Obviously, biosimilars will be more mature a year later and have a greater contribution to the PBM earnings.



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Two, and this is the one that's often missed is, we have a significantly sized exchange business. Even though it's only our second year back, we have about 1 million members. And so, this is a $4 billion or $5 billion business that in 2023 is not contributing meaningfully to profit. And we have the ability to reprice it. We may not get all the way to target profit, but we do have the ability to reprice it in 2024.

And one of the real advantages to getting this rapid growth is we now have scale. We have a scaled book. That was the challenge when we were re-entering it. So, we have this unique repricing opportunity to take something that's really not contributing and getting a contribution out of it. So that's one.

And then third, as always, is the ability to pull the G&A lever and get G&A savings, which, I think, again, making progress on the acquisition front has allowed us to sharpen our focus on where we need to invest. That allows us to pull back on investments in certain areas as we have clear direction on where we're heading. And frankly, as a large organization, I think there's always from time to time an opportunity to pull that lever. But all those things, I think, contribute to having adjusted operating income flat.

The next thing is a little bit of a mechanic below that. With the two deals we've closed this year, interest expense will annualize next year. So that will go up. That would be a drag. But we've also done some share repurchase already. And when you happen to look at those two things, they kind of wash each other out.

So that would still leave you sort of flattish, and we're looking for $0.40. When you look at Oak and Signify and you look at just their earnings growth for next year, that should add $0.10 to $0.15 by itself. And I go back to my strategy comment about adding 1% to 2% to the growth rate, you're beginning to see that already in 2024.

That still leaves us about $0.25 short. And I think, again, there's a G&A opportunity there to pull that lever hard, and that probably in total would be about $700 million to $800 million of G&A. Keep in mind, our G&A base is $40 billion, so that's still only a couple percent of that, which I think is quite an achievable number. And in all that, obviously, I've held our 2023 baseline performance flat. And I do think it's worth thinking about 2023 and it goes back to with all these things going on, I think sometimes people miss what's – can miss what's happening in performance.

You go back to Q1, Q1 was a good quarter. If Oak did not close early – we originally thought Oak Street would close at the end of the year. We always knew it would be dilutive. If that did not close, we would have raised the guidance for this year. And I think that core performance, despite the headwinds, is something that I think is important, because, as we watch this year play out, the better that baseline is, obviously, the more that carries us towards $9 in 2024.

**Question – Lance Wilkes:** Yeah. It makes a ton of sense there. And I think the long-term vision is one that's really interesting. Get to that in a moment when we talk more about health care delivery. But maybe we can just walk through some of the underlying components that we're talking about. So, maybe on the 340B risk, which is something that came up and you and I actually talked about this after your earnings call. Can you just talk a little bit about what's the sort of nature of the risk there and how you see that proceeding?

**Answer – Shawn M. Guertin:** Yeah. Right now, it's really purely a volume of claims risk. It's really not a is 340B going away. At least right now that's not what it is. It's about the volume of claims. So, what happened between our fourth quarter call and our first quarter call was there were three court cases out there.

One of them got decided, I would say, in favor of pharma, if you wanted to think of it that way. And a large manufacturer, basically what they did is they stipulated that the only eligible contract pharmacies that they would give a 340B discount to would be, think about at the hospital pharmacy itself or a specified pharmacy within a radius of the hospital. 40 miles was typically what was used.

So, what that does is it just dramatically reduces the number of scripts that they would qualify as a valid 340B script. Other manufacturers then followed suit. And so, you then begin to see this reduction in volume. And so, we had to make a decision to – do we just forecast what we know, the people who've taken action, or do we take a stab at, I think other people may follow suit. And we did the latter.

We took a stab at thinking other people would follow suit. That resulted in about a $0.07 net headwind. There were some positive things going on in the Pharmacy Services business that offset some of that, but that was about a net



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$0.07 headwind in our guidance.

In our planning when I was going through that logic before, I think it makes sense for us to plan that there could be more pressure on this in 2024. It may not happen. This is still a fluid issue. There's two court cases out there that have not been decided. I actually think a lot of the covered entities who benefit from 340B, with the expiration of the PHE, I think there'll be more pressure on this issue.

So, it's a little bit open still as to how this will all play out. But I think it's prudent when you think about the actions you can take now to protect, if you will, 2024, I think you want to be a little bit cautious in this area. So, this is really an ongoing somewhat dispute with sort of how people define contract pharmacies and 340B.

**Question – Lance Wilkes:** Perfect. So, now let's broaden it out a little bit. And I think one of the things that's been really topical for the sector has been PBM, FTC inquiries and House committees, and the like, and proposed legislation out there, Transparency Act, et cetera. Can you talk a little bit about maybe narrowly what you believe your exposure is to retained rebates and retail spread? And then, more broadly, like what do you see as the implications of these kind of policies on the earnings power in the PBM?

**Answer – Shawn M. Guertin:** Yeah. And I think there is no doubt a level of regulatory scrutiny that certainly I haven't seen in a long time at a specific industry. The ostensible focus has been on what they call network spread and retained rebates, and we can talk about that. But I'd also say it's important to keep some of this in balance and in your mind. This has been looked at before. And these investigations, in the past, have often concluded that it is a very competitive market with very sophisticated consultants, and that the PBMs play a very important role in lowering drug prices.

In fact, it's really interesting to think about this issue, and it sounds a little glib. But when you think about it, think who else in the pharma supply chain, who else has reason for being is to drive costs down for their customers. And that is the PBM and that's what the PBMs have done. So, it's an interesting place to put your regulatory focus when you're trying to drive – when your sensible issue is sort of driving pharma cost down, because that's exactly the mission of the PBM.

The other thing about this, when we think about the eventuality of where this lands – and I'll come back to the framing is how this market works. Most of the time the customers or the PBM are employers with large, sophisticated consultants, health plans also with their own staff and consultants. But a lot of what has happened is how they have elected to shape the economics. There's a lot of choices to make in how the economics of the PBM can be constructed. Some have elected to want all the rebates fully transparently passed to them. Some have wanted a guarantee of a certain amount of rebates. And then, it floats sort of around that. How we kind of construct network versus some of these other fees?

So, I say that because there's other ways in the economic model that we can adjust to if one of those things changes. And the other important part of this, if some of these things change, it could lead to higher costs for employers and health plans. And that's what they need to be cognizant of. But it is a very fluid economic model with lots of different pricing levers that have really been influenced heavily by the customer themselves. There's been numbers out there. There was a 20% statistic from one of our competitors and I should say fully upfront, there's a lot of decisions to make in how you do this math. And I do not know how they did the math.

But if I took sort of what I think would be a reasonable construction, our level of contribution, which was meant to be retained rebates and network spread is lower than that. And to some extent, I think that makes some sense because we've been charging pretty far ahead on transparency. We pass over 98% of rebates back to clients. I believe that competitive number was 95%.

So, where we would stand in that math makes some intuitive sense to me. So, it's those things that seem like they're in focus. I would say, via the 98% statistic, we're well down the path of passing those through already. And if network spread and things like that also sort of come in, there's other pricing levers, just admin fees and dispensing fees that we would adjust to.

So, there's a lot to play out here. I'm not cavalier about it or dismissive of it. It's a very serious inquiry at a level that I think is pretty intense. But I also think it's important to keep in balance the role we play, the adaptability of the PBM model and that the model is shaped a lot by the clients' desire for how they want the economics, and I think all that



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needs to be – keep in mind, we'll obviously fully cooperate and do – we're doing what we can to educate people on the model, the role we play, the results we have achieved.

**Question – Lance Wilkes:** Yeah. Okay. That's really helpful and thanks for the clarification on some of that numbers there too. Can you talk a little bit on the flip side? Obviously, those two are risks in that Health Services segment. Biosimilars is something that at one point people thought, oh, 2023 could be a big year. I think you and others pointed out that this might be a slower ramp in 2023 with that. But can you talk a little bit about as we look forward into 2024 and beyond, what biosimilars could contribute and how it might contribute, like what's the nature of the business model there with biosimilars.

**Answer – Shawn M. Guertin:** Yeah. So, I still feel very good about the near or intermediate-term opportunity around biosimilars. And what we've always said is one of the difficulties is, unlike pill and tablet generics, you're talking about big chunky drug, HUMIRA is the best example. But the timing has been difficult to predict. Some have come early. Some have been delayed. And you really get into some complexity about the concentration, the device, and interchangeability. And so, there's a lot that goes into pinpointing the timing.

I think for us, this year, we had the first HUMIRA alternative show up at the beginning of the year but we know there's a great number of them coming July 1. And from our standpoint, until you really resolve – our goal is always to get to low net cost for the customer. And until we understood more what was happening on the 7/1 kind of cohort there, it didn't make a lot of sense for us to go kind of do like a hard force on 2/1 if indeed you could come up with a better answer come 7/1 and have to switch people again. And it just didn't – and even therapeutically, we didn't think that made a tremendous amount of sense. So, that's why I think it has always been muted.

The other thing I would say to people in a general sense about this is, notwithstanding our previous discussion, there's two ways really to get the two that are emerging to get to a low net cost. You can have a higher cost, even think the branded product with a heavily rebated position that gets you to a net cost, or you can just have a low kind of – low acquisition cost drug without any kind of rebate. I think we have a preference for the latter over time. We think that's the right way to do it.

But some of what's been going on are people positioning. And many drug companies have both as an alternative. And so, you have to navigate through that as well. So, it's definitely having some benefit. And the business model in many ways is similar to what we went through on generics. You have the brand and there's not a lot of competition and you're not really getting a marginal contribution.

Then the alternatives come in and you can now deliver a lower price point, but you can even then deliver greater spread even with that lower price point potentially in the market just like generics. And in that way, it's very similar in concept to sort of what's happening. The complexities, though, of product introduction are greater and harder to predict. But the core issue is still let me take this thing that was a very high-cost brand and let me find a much lower price point to deliver it to the customer for.

**Question – Lance Wilkes:** Yeah, it's fascinating space and it seems like it's got a ton of relevance to the past patent wave. So it should present real nice opportunities. Let me shift over just a little – you got so many businesses, that's great. Let me hit Health Care Benefits. And probably the first question is just a combination of how's utilization looking thus far this year, given relative your expectations in pricing. And then probably, I think one of the things investors have been asking me a lot about is, what do you feel about reserving from first quarter and how confident you feel on the medical costs?

**Answer – Shawn M. Guertin:** Yeah. Again, just on the latter, I think I felt very confident with where our reserves ended the quarter. And we've talked a lot about some of the dynamics that can happen from quarter to quarter, but we have very well tested people and models that do that. So, we feel good about that.

What I would say about utilization is we've now gone in many ways back to where we have always been in managed care, which is it's really the matching of pricing and utilization that makes a difference in the long run. Utilization is up. We assumed it would be up in our pricing. And where in the first quarter what I would say – if you went back and you looked at last year, commercial had come pretty far back, was pretty close to what we thought was a normalized baseline. You still saw softness in Medicare and Medicaid last year.

I would say what's most obvious in the first quarter of this year is you've seen Medicare get a lot closer to that



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normalized baseline. Again, Medicaid actually still looks below. And in Medicare, it's some of the areas that you've all heard about with some of the public comps. You do see it in outpatient and ambulatory procedures and things like that more than inpatient, as an example. Inpatient still looks a little reduced to the baseline actually.

But I think you see Medicare kind of coming back. And so, we assumed – we've continued to assume a return to a normalized baseline, and I think our first quarter saw that that did happen more so in Medicare than what we've seen the last couple of years. But in anticipation for this, we did send out an 8-K and say we continue to believe that our pricing assumption is – or the utilization is consistent with the pricing assumptions we've made in the product. But it's definitely one of those things that has been a margin for error, if you will, in prior years with everything that's happened with COVID, that's a little bit different in the first quarter.

**Question – Lance Wilkes:** Yeah. Yeah. And then, you referenced the STARS mitigation process you've been going through. Can you just give people a little bit of color on kind of why the issue happened in the first place, what you've done to address it, and kind of what your outlook is right now?

**Answer – Shawn M. Guertin:** Yeah. So the STARS is a program which we have performed well for probably over a decade. And generally, if you're over 4 stars in a given plan, you get a 5% bonus. There's a few other mechanics that are beneficial to you, but if you thought about it that way. And then, you can use that bonus to basically deliver more attractive benefits and thus get greater growth in the product.

Again, we've consistently been in the upper 80s for a very, very long time. We came exceptionally close but fell just short. And I can't even describe to you how close we actually were to getting 4 stars. And the reason I say this is to not whine about it, but I think it's relevant when you think about the remediation, where we were starting from.

We were starting from an okay place, but we fell just below that threshold. And we have one contract which has grown a lot as we've expanded. It had all of our group – most of our group membership in it and a great deal of our individual membership. It was probably 1.8 million, 1.9 million members or something thereabouts.

And just to put this in context so people understand this, the area that caused us to slip below this is what's referred to as CAHPS, which you can think of as sort of a customer satisfaction survey of sorts. They talk to 974 people out of 1.9 million. So, that's a little frustrating from our standpoint. But again, with that result, which got us very close to the borderline, we came up short.

One of the tricky things about STARS is when you find out you've missed, you're in the middle of the next grading period, so it's a little bit of a rush then to figure out what you can do so that you can get it fixed in time for the next year. That's often why – this has happened, I think, at one time or another to virtually every big MA player, and sometimes it can take two cycles to fix it because of that phenomena. But we've really put – we've done some things to diversify ourselves off that contract so that we don't have so much membership all stacked on one contract. That will largely be kind of separating some of our group membership from our individual membership is a good way to think about it. But we've really had to go back through how we do this, how we monitor it.

We've looked at everything that can play into these surveys, and I share that example about 974 people and 1.9 million members to say, when you think about fixing it, you really have to think about things that would touch a lot of people, such that if they're surveyed, you've sort of done the right thing. It can be hard sometimes to figure out where to focus (00:28:38). But we did find a number of areas.

So we won't know definitively because we can – we're coming up basically at the end now of the period. So, we know – we have a good idea what we think we've done. What we don't know is where CMS will set the cut points. In other words, they can move the bar every year based on how people are performing as to what in their view constitutes a 4 star level of performance.

So, we can see – we believe we can see where we are. We don't have all the final answers back from CMS yet, but most importantly, we don't also have the cut points. So, we can't really make a definitive conclusion. But we've done everything we can. We've invested. We've changed a lot of process to try to get this fixed.

**Question – Lance Wilkes:** Yeah. And just one other question on Health Care Benefits and Aetna. You had a personnel change. So you brought Brian Kane in. So maybe just a quick comment on kind of the logic there in Brian



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as an addition to your team.

**Answer – Shawn M. Guertin:** Yeah. The change, just to be clear, was really due for personal health reasons and we needed to find a new leader. And we were very fortunate to find somebody like Brian. I know Brian well, both from his time at Goldman and his time at Humana. And when you think about the strategy I described, the manifestation of that strategy a lot of times has value pools in the payer model or can have value pools in the provider model.

Brian has lived in that world and has experience, and Brian's deep understanding of the business will be helpful in running that business, number one. And I'd also say, for those of you, one of the things that even struck me when I came back was how much the story of what Aetna is has changed. I mean, 70% of the premiums are now government programs, 30% are the membership. I think, 15 years ago that was probably 5% or 6% of the membership was government. So it's much more dominated by government programs today. Commercial is still a very important business to it, but where it used to really be a commercial story, it's as much a government story as it is a commercial story. Brian, obviously, knows that very well.

And in this industry to find experienced people who really know both how the financial levers work, but how to operate those levers and, I think in Brian's case, how does this strategy manifest itself in value, I think it's a real unique opportunity and I'm very excited to have someone like that join the team.

**Question – Lance Wilkes:** Yeah. Great addition. Let's talk a little bit about the health care delivery business and maybe just start off with – I know you framed a bit the vision for the company, maybe the vision for health care delivery. What that's going to look like? And then, probably as a follow-up, talk a little bit about the phasing of growth with Oak Street and beyond.

**Answer – Shawn M. Guertin:** Yeah. So, in terms of what it's going to look like, what I would say is we're not necessarily trying to construct a bunch of traditional doctor's offices at all. We're really focused on next-generation, value-based, tech-enabled models. And the thing I think that can make us unique is we have an ability to engage the consumer and bring a lot of other fulfillment assets to that.

I can tell you, when we've talked to every kind of value-based player it seemed like under the sun at some point, they all immediately got excited about the simple integration of pharmacy into their clinical experience. And that's one is that is customer convenience. But another part of that is having access to pharmacists for therapy – or medication management reviews and things like that.

But again, if you think about we should be able with our pharmacy assets, with our understanding of brand and bring these clinical and these consumer assets in a way that creates a consumer experience in health care that is differentiated from the traditional experience that we have. And that, I think, is at the heart of what we're doing.

So, someday what this could look like – and I describe this as concentric circles is, at the innermost circle, today we have Oak Street as a value-based clinic model. But you would have hundreds potentially of clinic-focused entities, value-based care. Over time, I could see the application of those models to Medicaid or the exchange membership.

They then might be surrounded by what I would think about as a support structure of episodic care or urgent care. So, think MinuteClinic and HealthHUB that idea, but a version two of that idea. We've made an investment in a company called Carbon on the West Coast, which is doing this, a very tech-enabled model. And we're thinking about the union of those two things.

But if you think about they then become a support structure for that inner model. And when people need to go get something done or your telemedicine says you need to go get a test done or you don't need to go to the ER, you can go to these. They're there to support that model. So, they can play, I think, a very, very big role in that. And so, those stores as you look at them today might start to look a little bit more urgent care clinic wise. They could have more of a retail presence, but it might be very health and wellness focused. Think about over-the-counter, DME, or things like that.

And then, of course, you'd sort of have what you think of today largely, which is your pharmacy chains, but I think with more of a health care pivot. The thing about that, though, is that what's really important about that is I see that



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this is linked in three ways. We would have the brick-and-mortar community footprint that I just described, but we'd also have care in the home, and we'd also have virtual care. And they would not be three silos. They would be three interconnected parts of one delivery system that would complement and support each other.

So, if you went in – over the weekend, you went into our virtual care product or you went into a MinuteClinic, your Oak Street doctor ideally would know that on Monday morning if they came to work then, that you'd had a visit over the weekend and would be very – and it's all part of that customer convenience.

I think one of the things that's really interesting about this model for someone who's been in the industry for a long time is for decades, we tried to change people's behavior to get to better outcomes through financial incentive and disincentive. And what these models are teaching us is that the way to do that is through convenience. And the example I would use is in the old days if somebody wanted to go to a cardiologist, you say, you have to go get a PCP referral. People rebelled against that, and it ended up kind of crushing the whole model.

But today, through technology, I say, you need to go see a cardiologist and, oh, by the way, you can make an appointment with our digital app right now, here's the list of five doctors. They've just done the exact thing that we've sort of said these are five high quality doctors we think are efficient.

So, it's an example of how convenience can shape behavior. And this is really important, because I think we've known what to do in health care for a long time. The unlock has been how do you engage and influence and change behavior. And I won't say convenience will solve every problem, but I think we're seeing it's a big part of the solution that, frankly, has been accelerated by the pandemic, I think, in people's minds.

**Question – Lance Wilkes:** Yeah. I'm a big believer in that particular model. And again, just shifting from like a friction-filled model of benefit design to a model where the pen and the doctor are doing the same thing really. Could you talk a little bit about – you've talked about 300 Oak Street clinics by, I believe, 2026. And one of the things that I've wondered about is the opportunity to do more clinics that might sit within CVS' or different models down the line. Have you thought about that? Obviously, you've just recently closed Oak Street, but what's kind of your view of what those clinics will look like over time? And could it be like another phase of rollout there?

**Answer – Shawn M. Guertin:** Yeah. So, it's a really good question, because obviously when we closed on Oak Street, they had been moving at a pace that was opening, call it, 30 to 40 new clinics a year. And what's really important about this, to think about this model and the J-curve of their business is we think – and they've demonstrated this to us in some of their mature clinics – that each one of these clinics has a target adjusted EBITDA maturity of $7 million.

So, when you think about having 300 of those, you're creating an infrastructure to have the capacity – not necessarily in year three, but to have the capacity to produce $2 billion of EBITDA. And so, what you're setting up is bigger and bigger waves of sort of embedded EBITDA. And so, no matter how you look at this, you will conclude that it's a good long-term decision to accelerate clinic growth now. And I think we will do that. We will set out to go faster than 30 to 40 a year.

The question is, sort of what's the best vehicle for us to do that? How do we do that? But there's still a lot of demand not only among – for Aetna membership, it's amongst all the payers have a demand. These are very high performing clinics. They've demonstrated over time that they can deliver results. And a lot of this – there's been a lot of questions because of some of the things in the Medicare rate notice that have come out.

In some ways, I actually feel even more so that these assets are important. If you think about – even if you think just generally reimbursement won't be as rich, well, you really need then assets that can sort of optimize the delivery of care and reduce the cost of care, which certainly Oak Street can do. And so, it is, I think, very likely we will move on an accelerated pace to get to at least 300 by 2026.

The other thing that we have which is not necessarily the reason we did it, but it's a decent outcome is as some of you know, we went down a path a year or so ago to close 900 stores, about 300 a year. We're in our second year of that. When we did our analyses of that, there were probably opportunities to go further than 900. But remember, it was still during the pandemic as well. If we had done that, we were creating some deserts, if you will, for pharmacies and community locations. And so, we didn't do that in some areas.



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The demographic that Oak Street targets is 300% or less of FPL. There's an alignment here with some of those store locations I just described. Frankly, there's an alignment in some places where we have already closed stores in those communities. And you could certainly construct an argument that the clinic with the pharmacy is even better for that community than just the pharmacy was.

So, I think there's some real opportunities both for us to find ways to move faster than 30 to 40 clinics per year. I think there's ways to utilize our existing assets to do that more quickly. And I'm very – I'm confident that we can get to 300 or better by that timeframe. We can grow this faster.

**Question – Lance Wilkes:** Yeah. We're getting close on time, so I'll prioritize these questions. The one that I think is the most powerful in this value-based care space to me is the different synergies and the different impacts on an integrated basis across CVS that having this model might have.

So, could you talk a little bit about maybe how you're looking at this and consequently how you're planning for things like shifts of Aetna membership to drive (00:41:31) patient growth or having the capability of Oak Street to drive up MA membership growth? Could areas like Medicaid or individual be packaged together? So, how do you prioritize those and (00:41:44)?

**Answer – Shawn M. Guertin:** Yeah. And there's an important part in everything I'm going to say on this, which is these assets are all multi-payer assets and will continue to be multi-payer assets. Obviously, we have some more control over the Aetna membership to potentially move some of that. For example, Aetna membership is underrepresented in Oak Street today. So, we have the ability to, obviously, have more influence on that. It is not necessarily to convert other people to Aetna. That's not really what these assets do. But there's some really powerful examples of how these assets can work together.

When Signify is doing home assessments, they would estimate that about 30% of the time they run into somebody who either does not have a primary care physician or is not actively engaging with one. The ability to return that person to care through potentially Oak Street, potentially even expanded MinuteClinic operation, that is a very powerful opportunity we have to sort of grow those businesses. But most importantly, this is one of the policy priorities for CMS.

A lot of what CMS has talked about vis-à-vis coding isn't really just about coding only. It's about, if you code somebody and they have condition A, then let's get them returned to care for condition A. Well, this example I describe does precisely that.

To your point, I think some of these locations, some of the dynamics of the other products could also play in Medicaid and exchanges, I think, are natural components. A big thing in Signify is that you get long list of people to engage. And they don't – or they might engage 20% of the people or thereabouts. We think we can dramatically increase that engagement.

The first thing they wanted was the CVS brand to use for that engagement thinking that that would lead to a sort of better engagement. They run into people who don't want the home assessment but might be willing to do it at another location. Thus, the community location of a MinuteClinic could potentially be that.

And then you bring in everything pharmacy. One of the first things they do in these home assessments is get all the prescriptions and lay them out on the table. What they don't have is the real time sort of access potentially to pharmacists to look at that and sort of help them sort of through that.

So, the ability for us, frankly, to increase the conversion, increase the growth in these businesses is one, but also the ability to improve the care models in these businesses through all the other fulfillment assets we can, can drive a lot of strategic value. And that's not only for Aetna. That's for all the payers. And that's really important, because if we come up with a better post-acute discharge program for Signify, that's going to be for all payers, not just Aetna.

**Question – Lance Wilkes:** Yeah. So, we're just about at the end. Let me wrap on one question – if it's quick, we'll get to one last one – which is kind of M&A priority. So, over the last few years, obviously, CVS with Aetna, but then with Signify and Oak, you guys have been very active and been looking at a million things. How long does it take to digest? What should we think of the priorities kind of in that kind of post digestion time period?



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**Answer – Shawn M. Guertin:** Yeah. I mean, I would say the – we won't be doing anything imminent of sort of the ilk that we just did. We have a lot to do, make sure we get the synergy realization. Now, in fairness, I would say these aren't classic acquisitions where there's a lot of overlap with what we do either, can take a lot of time. These are much more capability based and new. So, the nature of integrating them is different and in some ways simpler.

But we need to make sure that we actually get – we get them aligned in the organization and that we really then prioritize the biggest value ideas, because there's a lot of good ideas on how this – how we could use these assets to drive value. And we want to make sure that we work on the best ones. And so, we're continuing to spend time on doing that. Obviously, we had less time on Oak Street than we had originally thought to do that. But we're moving really rapidly on that.

So, I think what you would think about on M&A going forward is I think, undoubtedly, there are complementary assets out there that we could pursue. We've talked a lot about doing more in the home, for example. And so I think over time, we've talked about provider enablement, of which we have some capability now. But those things are intact. But I would say, right now we really have the core anchor assets that we wanted and we need to ensure we deliver on those before we move on.

In the future, you could also certainly see activity that's more akin on some of our existing businesses, whether it be pharmacy based or something like that as well. But right now, I think we're more focused on digesting what we have and rebuilding kind of our financial firepower.

**Question – Lance Wilkes:** I guess the last question in the last couple of minutes here would be over on the filled retail (00:47:14) operation, so the pharmacy and consumer operations. Can you talk a little bit about kind of what has been – what's going to be the key value proposition in that business on a go-forward basis? Maybe contrasting with online competitors like an Amazon and, obviously, the people you're taking share from today. And what are the prospects for other important earnings drivers there, whether it's automation or other process (00:47:40)?

**Answer – Shawn M. Guertin:** Yeah. On our retail business, the thing I would say to import (00:47:46) is I would actually say the challenges we've had have been fairly well known, but really the RX reimbursement pressure issue, which is from PBMs, is really, I would say, the most meaningful issue. The channel competition is there, but honestly hasn't – we've taken market share in the pharmacy, I think, every quarter since Q1 2020. So, our omni-channel offerings, our digital investments, some of the new capabilities we've been bringing to bear, a lot of that has worked.

Our NPS scores are up in the stores. We're taking share. So, we're doing the right things. We can always do better, but the pharmacy reimbursement pressure has been the challenge. But I think what it will do as some of this has gone from driving people to specific channels to letting them select the channel and us being somewhat indifferent to that. You want to mail it to your house, you can mail. You want to pick it up, you can pick it up.

We can do this a lot of different ways. And there's different things we can do to sort of complement the front store role in that I think as well that we're continuing to invest in. Having said that, it's obviously not a business that still has its set of challenges year in and year out, but we've done a good job of growing share.

Great. Well, I think we're like right at the end here. So, appreciate everybody taking the time today, and we've got a few more of these coming up. Hope everybody has a great rest of the day. Thanks so much, Shawn. I really appreciate it.

Sure. Thank you, Lance. Thanks, everyone.

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