CVS Health Corp

Raymond James Institutional Investors Conference - Fireside Chat

Tue Mar 05 2024 Conference Transcript

Raymond James Institutional Investors Conference - Fireside Chat *(Corrected version)*

Summary NEW

SMART SUMMARY

Positives

- CVS has converted two large Blue's plans to their integrated Aetna Caremark product over the last two years.
- The integrated Aetna Caremark product has shown benefits like lower hospitalizations and better medication adherence across 18 million members.
- Oak Street clinics performed well in 2022 despite Medicare Advantage pressures, and are accelerating expansion by 50-60 clinics this year.

Negatives

- Aetna's Medicare Advantage business will face significant headwinds in 2024 due to a drop in star ratings, with an estimated negative impact of around $800 million.
- Aetna has seen more utilization pressure in 2023 than originally projected, which will continue to negatively impact results in 2024.
- Aetna and Humana are making little to no money in Medicare Advantage in 2023 due to tough rate notices, so the industry needs to recover margin in 2025.

Outlook

- CVS Health said outpatient results in January have been consistent with expectations, while inpatient has been noisy due to respiratory issues and changes in the two-midnight rule.
- CVS Health said trends have shown more pressure than projected, which will continue to pressure results in 2023 and 2024.

Q & A Highlights

- **What is your perspective on the situation with Change Healthcare being fixed?**
- The speaker has not received an update that the Change Healthcare situation has been resolved, and it would be great if it was, but CVS has been working on alternatives in case it is not.
- **How should we think about the multiyear margin goal evolution and limitations, and is 2024 the trough year?**
- The multiyear margin goal is limited by trend acceleration and stars ratings. 2024 is expected to be the trough year before recapturing margin in 2025 with rate improvements, reviewing each block of business, and adjusting benefits and geographies within TBC limits.
- **What is the progress on CVS' CostVantage initiative to change the generic drug pricing model since the last analyst day?**
- CVS has seen some pressure in Medicaid reserves due to redeterminations and acuity, but Medicare estimates are mostly holding from Q4 2022, with inpatient and outpatient results consistent with expectations in January.
- **The question is asking about volume trends in January for hospitals and surgeries based on data from Kaufman Hall and a survey.**
- The data from Kaufman Hall showed a 3% increase in surgeries in January while a survey showed a 7% increase, indicating volumes were up in January especially on the hospital side.
- **The question asks about the evolving role of discount cards like GoodRx and the cash model in the pharmacy industry over the next few years, including its interaction with PBM contracts.**
- The answer states that discount cards like GoodRx aim to eliminate inconsistencies for consumers at the pharmacy counter, but CVS is trying to create the same transparency through linking their models so that discount cards are not necessary, as cross-subsidization of certain drugs will always occur but the model needs to be simplified.

Event Details

Date: 2024-03-05
Company: CVS Health Corp.
Ticker: CVS-US

Company Participants

Thomas F. Cowhey - CVS Health Corp., Executive Vice President & Chief Financial Officer
Unverified Participant

Other Participants

John W. Ransom - Analyst

MANAGEMENT DISCUSSION SECTION

John W. Ransom

So, good morning, everybody. We're very happy to have CVS back after a lengthy absence. I don't think Larry Merlo felt the greatness last time he was here, so they boycotted us for about a decade. But we're back. And so, obviously, it's great timing. Lots of topics du jour. So, I'm glad we're doing a fireside chat, because we can kind of go down some alleyways and make Larry nervous over there. But we'll keep it – we'll stick to the script.

QUESTION AND ANSWER SECTION

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Analyst: John W. Ransom

Question – John W. Ransom: So, let's just shoot one of the elephants in the room. Yeah. News is breaking that the Change Healthcare situation is either has been fixed or is fixed. What's your perspective on that?

Answer – Thomas F. Cowhey: So, let me just – so, thanks for having us. But let me just start by saying that we'll make forward-looking statements today. So, you should look at the risk factors that are contained in our SEC filings.

If Change is back on, that's news to me, because we've been here talking to investors this morning. So, I haven't gotten that update. As you think about what the impact to us has been, generally speaking, at this point in the year, as you think about January and February claims, you have pretty limited visibility to begin with. It's early in the year. You tend to, when you close a month, know about 30% of what has happened in the month. And when you go back two months, you know 60% of what happened and that kind of cascade rolls forward.

For us, Change is about a quarter of our claims and most of that impact is actually on our Medicaid business. Almost all of that runs through Change for our pharmacy business. There are certain states where our Medicaid pharmacy claims have been impacted by that and the teams are working through workarounds.

So, if that's back on, that's great. Our teams have been actively looking at what are alternatives to Change. How can we get direct? How can we go through other exchanges to make sure that those claims arrive in a timely fashion? And our goal was to have better visibility by the time we close the quarter.

Question – John W. Ransom: And when you speak of Medicaid, this would be Medicaid Managed Care or this be straight Medicaid?

Answer – Thomas F. Cowhey: No. Our Medicaid Managed Care.

Question – John W. Ransom: Medicaid Managed Care. That's right, because I don't think Change – Change doesn't get in the middle of straight Medicare or Medicaid from what...

Answer – Thomas F. Cowhey: No, no, no. We are in the Medicaid Managed Care businesses, which are on different platform than some of our others and all of those are tied to Change.

Question – John W. Ransom: Okay. So, turning to the topic that I'm certain you're tired of talking about, but always.

Answer – Thomas F. Cowhey: It's fine.

Question – John W. Ransom: So, kind of a multipart question. And if I ask it poorly or clarification, please tell me. So, we look at Medicare Advantage in two of the three biggest players, namely yourself and Humana are making little to no money this year. It was another tough rate notice. So, the industry is, I think, in lockstep that we've got to recover some margin in 2025.

Now, that's a more complicated picture for you. And so, talk about how you would go about recovering margin, especially in light of the limitations of some of the changes in Medicare Part D, the TBC factor and some of the competitive dynamics.

So, let's think about kind of the multiyear margin goal and what the limitations are. In other words, you can't just go cut $100 a month out of benefits and get it all back in one year. So, how should we think about that evolution? And do you think that 2024 is the trough year or is it too early to make that call?

Answer – Thomas F. Cowhey: So, I hope that 2024 is the trough year. As you think about Medicare, as we entered into 2023, we thought that we priced to a 4% to 5% margin on that business and we thought that we would be in the middle of that range as we thought about what our outlook was for 2023.

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We priced for 2024, as we always do, in the first week of June. And so, as you think about that cascade of claims, plus the time that it takes to process all the bids in all the counties that we're making, you're making your forward assumptions on trend based on paid claims through the first quarter, a little bit of the second, but not a ton of visibility on some of those later months in the second quarter.

And that's exactly when we really started to see trend accelerate, right? So, that's where we started to see pressure. Some of that pressure manifested itself on the first quarter through the run-out periods. But then, in the second and third and we saw elevated trends into the fourth.

And those trends, when we made our bet in June of 2023 on what would be the remainder of trend for 2023 and what would it look like in 2024, we made assumptions about enhanced utilization as we typically do. And we've seen a lot more pressure than we otherwise would have projected at that point in time. And so, that pressured results in 2023. That will continue to pressure results in 2024 and that's fully reflected in our guidance.

So, 2025 then becomes a year where we're going to be looking to recapture margin. We have a mid-60s-billion-dollar revenue business in Medicare this year. We've seen very strong growth. We've talked about at least 800,000 members of growth throughout the year. I would say the likelihood that we exceed that floor is high.

So, I think that's probably not a surprise to a lot of our investors. We think it will be north of that 800,000 floor. And as we look at that growth and we can talk about this maybe another question if you want, but we feel about 30% of it is coming from duals, about 70%, 75% of that is switchers. That's helped for some of that new cohort growth to be more neutral to our earnings profile than one might typically see.

But as you look forward then to 2025, you also have to realize that, for us, 2024 is a trough year, partially because of stars. So, our largest contract fell from 4.5 stars to 3.5 stars for the 2024 payment year, and that will go back to 4 stars for the 2025 payment year. That, we've talked about the headwinds being about $800 million inside this calendar year. We'll get most but not all of that back into 2025. And so that in and of itself will assist as we think about what that margin progression from 2024 to 2025 will look like.

As we then think about where else can we recapture margin, we're going to have to look at this kind of contract-by-contract, geography-by-geography. We will look at each of our different blocks of business, whether that's our Duals business, our group business, our general enrollment business. We'll think about supplemental benefits. We'll think about core benefits and we'll make adjustments. Now, as you noted, that's subject to a cap, the TBC limit. And we'll obviously be paying close attention to that and any particular geography.

That limit comes much more into play if trends are higher than the rates. And I would say, based on what we've seen in the preliminary notice from CMS that those rates are insufficient. We've provided comments on that. We'll see the final rates in early April. There's a couple things that I think should help those, all other things being equal, which would – as you think about perhaps the inclusion of the fourth quarter data on trends, which were higher than what we had seen year-to-date September, that should potentially improve rates.

There's also some work that's been done biweekly that suggests that perhaps there's been an overreliance in some of the regression models that CMS did on bringing the COVID periods back in. That could also be a tailwind to rates. But CMS has a lot of discretion, and we'll have to see how that ultimately plays out as we see the final notice in April.

Question – John W. Ransom: So, not a question, but kind of a comment. I think it's interesting to see where CMS is because, at the same time, they've squeezed MA the past two years with effective price cuts when you roll in Tukey and stars and now they're saying they are conceding that V28 is like a 7.5% bad guy. They said it was 2% bad guy last year. But at the same time, they have been giving providers fairly generous rates. And so, they acknowledge the inflation with some of the provider updates, but for the plans, they're squeezing the plan. So, why is that?

So, the hypothesis that our team has, and I'd like you to – this was not on the script, so you can pass on this question. But we think that CMS is effectively saying maybe the supplemental benefits and the actual value of these plans got a little bit out of hand. That was something that plans said themselves. And so, let's just try to bring, fee-for-service and MA more back into balance. And so, they don't really care that the plans have to eat some margin for a little while, but it just got excessive. The 40 plans for beneficiary, all the marketing, the supplemental benefits, et cetera, etcetera. So, do you think that's a reasonable take to kind of describe what's going on or do you think it's different than that?

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Answer – Thomas F. Cowhey: I think that – it's hard for me to talk about how CMS is thinking about this. I think the practical reality, as we think about our mid-$60 billion business that's marginally profitable this year, how do we get back? It's going to be a multiyear journey, right. What are some of the things that we're going to need to look at?

I think supplemental benefits has to be on that list. So, whether it was intentional or not, I think, ourselves and probably the industry are going to have to look at all the benefits across the board and decide where it is that we want to cut. But I know that supplemental benefits will be part of that conversation.

Question – John W. Ransom: Great. Okay. Let's put Medicare Advantage to bed. I think we've – and we'll leave a little time at the end for some follow-up questions. The company made some news at the Analyst Day about two initiatives you're working on. The one I want to focus on a bit more is the CostVantage and the retail.

So, for people who aren't deep in the weeds on CVS, maybe just kind of reset what CostVantage is and sort of what's happened qualitatively since the Analyst Day, since you've made this public splash if you want to change. And I'll preview by saying generics are 90% of the volume that a drug store does approximately. The pricing is based off something called AWP, which has nothing to do with the cost of the generics. There is kind of a minimum dispensing fee involved, but the contracts are still written on AWP. And you look at Walgreens, Walgreens has lost probably a 1,000 points of gross margin in its pharmacy if you do some backward math. So, yeah, clearly, something's broken in how this is priced for. But just talk about how CVS being both a payer and a big retail chain intends to try to move that to a different structure?

Answer – Thomas F. Cowhey: I think people are going to hang us by our toenails if we don't talk about Medicare trends. So, if you want to hit that first or...

Question – John W. Ransom: Tom, I'm at your disposal, please.

Answer – Thomas F. Cowhey: So, we've been getting a lot of questions about what is it that we've actually seen. So, the Change thing aside, right, so whatever visibility you thought you might have early in the year, you've got less visibility than you would at this point in time because of what's been happening with Change. So, beyond the normal caveat of it's early, just recognize that the Change situation complicates your visibility at a time where you don't have a ton of visibility to begin with.

And so, if you go back and think about what we said in the fourth quarter, we said, hey, we looked at the fourth quarter accelerated versus the third. Where did it accelerate? Accelerated, we saw an acceleration in outpatient. We saw continued high levels of trend in some of our specialist categories, things like dental and vision, right? Not the OTC cards that we talked about in the third quarter. And you also saw some pressure in our medical pharmacy category, which included things like immunizations. So, we're pretty comfortable with where that landed.

We took pain to take a hard look at inpatient. That category was in control for the most part. And we pulled forward the pressure that we had. We annualized it into the fourth quarter, and we assumed a normalized level of trend on top of that, as we think about 2024.

What do we know now? As we look at the fourth quarter, our estimates are mostly holding in Medicare. Now, we've seen some pressure in the reserves on the Medicaid business. Some of that we think is acuity-related redeterminations, and we think that there's going to be advocacy rate offsets on that. A little bit of noise in Individual, nothing that we're worried about. Group Commercial seems to be holding. But, importantly, the fourth quarter on Medicare seems to be holding. So, we feel good about where that's developing. And inpatient in the fourth quarter appears to be holding.

As we look at what we've seen in January, we've actually seen results that would be consistent with our expectations on outpatient, right, which is great news, assuming that that continues to hold. Inpatient has been a little bit noisy. Some of that is respiratory related. Some of that also is, we've got this change in the two-midnight rule that went into effect that we priced for. But we're trying to – when we get a little bit more of the run-out data, we'll have a better sense as to kind of what we're seeing there. But, for now, I would say we feel reasonably good, which is why we reaffirmed the guidance this morning.

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Question – John W. Ransom: So, Kaufman Hall had volumes up 3% that was surgeries, so that wouldn't capture the flu, but it would capture surgeries. And then, I saw a survey today like up 7%. So, it is running. January looked like it did run a little hot on the hospital side. So, okay.

Answer – Thomas F. Cowhey: And then, CostVantage. So, CostVantage, think of this as in some ways we got to start to think about how did we get here? So, if you go back 10 years, I don't know that anybody thought that we were going to get to 90% generic dispense rates in the pharmacy. And part of the way that we drove those generic dispense rates up is that the plans incented the pharmacies to try to do that. And what we wound up doing was we wound up cross-subsidizing.

And so, we make most of our money in the pharmacy on a subset of generic scripts, not even all generic scripts. And part of what we're trying to do with this new model is to actually eliminate some of that cross-subsidization. On top of that...

Question – John W. Ransom: If I could just stop you, what would you say – I mean, I see sometimes $3 generics, $5 generics. What's the floor where it's just not worth your time to – I mean, you lose money on the script. I mean, let's ignore the ingredient cost for a minute. But what's kind of the minimum dispensing cost per script that you would need do you think?

Answer – Thomas F. Cowhey: We haven't talked about where the specific pricing on CostVantage comes out. So, I don't want to talk about that in this forum. I understand why you're asking the question.

There's also two things you got to think about. There's what is it that CVS Pharmacy is charging to the PBMs? And then, how is it that the PBM is adjudicating based on the client preferences, the cost of that script at the counter? Right? And so, it's essentially two transactions and they aren't necessarily connected. That's where you say what's CostVantage? CostVantage is creating transparency in the first part of that relationship between CVS Pharmacy and the PBM. TrueCost, which is the PBM model, is creating the transparency end-to-end between how the PBM is pricing it and how the consumer is experiencing it at the counter.

What CostVantage does is it levels the cost subsidization. There is none, right, and it limits the rate of decrease in pharmacy prices. Now, when you level-set, you're going to see some movement, right? So, that cross-subsidization may result in certain prices going up and other prices going down, but the basket of prices should stay relatively constant and the basket of prices will continue to decrease in price over time as we pass through the cost of the goods improvements that we go out and get, because the new CostVantage model is, whatever we paid for the drug inside a relatively narrow band because we can't specifically expose our acquisition cost based on the nature of those contracts, but in an honorable and tight band, plus a small markup, plus a dispensary. Very simple model. And what TrueCost does is allows the consumer to experience that.

Now, what we're also doing with CostVantage is we're creating that cash discount model in the second quarter at the pharmacy counter if a customer wants to pay cash for their drugs and go outside their benefit.

Question – John W. Ransom: So, on that point, go down a little detour, we do follow GoodRx. And GoodRx originally was a PBM-driven algo, 12 price points, AWP-based. And even GoodRx, I think, for large pharmacies is moving more of an engine behind the scenes to offer a price.

And our conversation with them, I'll say, for right now, it's kind of focused on drugs on formulary and then they're contracting direct with retail, large retailers like yourself. But just talk about how GoodRx and the evolution of the cash model looks. And I'm not asking you to talk about GoodRx. But it's just confusing to us how all this looks two or three years from now and just what the role is of the discount cards and how that also affects your most favored nation contracts where you can offer a lower cash cost than your PBM price to, say, OptumRx. So, just maybe take a swat at that big fat pitch.

Answer – Thomas F. Cowhey: Yeah. This is – why is this so complicated is really the answer to your question, right? It doesn't need to be.

And, part of what those models do is they try to help eliminate some of the inconsistencies for the consumer at the counter. And what we're trying to do is create the same transparency through the interlinkage of these models, so that

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that's just simply not necessary, because it's that cross-subsidization and listen, clients are always going to want to subsidize certain drugs up a counter, right? They want to ensure that there is maintenance medications that are taken despite economic condition or class. But at the end of the day, we just simply need to simplify a model.

Question – John W. Ransom: My question and this is a benefit – I'm on a benefit committee. My question is why would we not, just with our premium and plan design make these 100 generics free? Why do we charge for blood pressure medicine? Why do we charge for cholesterol meds? They're single-digit price drugs, very effective, multiple source. Why even – we don't run windshield wipers through auto insurance. I mean, this is equivalent to me running the windshield wiper through Allstate. So, we don't do that on that side. Why do we even have this superstructure for $3, $5, $8 transactions?

Answer – Thomas F. Cowhey: I mean, could we do something different? Absolutely. Right. At end of the day, it's partially about what it is that the plan sponsor wants to incent at the counter.

Question – John W. Ransom: Yeah. Okay. So, the company had an interesting journey on the M&A front, spent $20 billion-ish on a couple of acquisitions. I think you'd get an incomplete grade, not a passing or failing, but maybe an incomplete. But just kind of where you sit, the Oak Street deal and the Signify deal, what grade would you give those two? What surprises, good and bad? And then, outside looking in, you've kind of buried them now in the PBM segment, which I'm mad about. But what should we be looking at outside the industry, how you're doing on that rather large capital outlay?

Answer – Thomas F. Cowhey: So, we were very clear about what it is that we were trying to do. We felt that we needed capabilities in Advanced Primary Care, we needed capabilities in Physician Enablement, and we needed capabilities in the Home. And with our two acquisitions, we feel like we got a strong foothold and platform, foundational platform across all three of those.

So, Advanced Primary Care, we think of that in many ways as your staff model. That's your Oak Street acquisition. Your enablement piece is really your affiliate model if you want to think of it that way. And the combination of what we had built internally through the CVS ACO, the very strong Caravan business, and also some of the capabilities that we have from Oak. We talked about this at Investor Day. We have a growing enablement business that we feel is making great traction in the marketplace. And then we have Signify in the Home, which is a business that sends clinicians into the Home, but isn't a clinical home-based business, right?

What is it that we think that we can do with these acquisitions? Well, we want to be able to bring those individuals and allow them to experience some of the services that we can provide as an integrated enterprise. And so, think about what we can do to help expose those services to the 85% of Americans that live within 10 miles of CVS. There's 5 million people that walk through our stores every day. I think, it's on average there's 1,000 Medicare seniors that purchase a product in one of our CVS stores every week. And there are three CVS stores in every Oak Street MSA. Right?

And so, there's a lot of interconnectivity. And as we think about some of the benefits of what we can do as our enterprise, I'd point to probably two things that we've done. The first is the integrated Aetna Caremark product. And the integrated product, I think we've got about 18 million members in that product today. We see lower hospitalizations. We see better medication adherence. Across the board, we just see tremendous benefits of that.

Question – John W. Ransom: What's the difference in that plan design that drives those outcomes?

Answer – Thomas F. Cowhey: I think it's the coordination.

Question – John W. Ransom: Okay.

Answer – Thomas F. Cowhey: Right. As you look then at our individual business, our individual business, the Obamacare exchanges, if you want to think of it that way. We grew that business from less than 100,000 members to 1.3 million, 1.4 million members at the end of 2023. And we grew in line with the market. We've got over 1.6 million members in that block today. Now, a lot of that has been redeterminations, have made that a very viable alternative for some of those individuals. That's actually our first co-branded Aetna CVS product. And we see a couple things there

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that I think are really interesting. MinuteClinic, which is a very good value. They have no-cost or low-cost options there. We see twice the utilization among that population of MinuteClinic as we do amongst our general populations.

And as you think about just Pharmacy share, our General Pharmacy share is about 26%, 27% according to IQVIA. We see nearly 50% of prescriptions from that population being filled at the CVS Pharmacy. So, there's a tremendous amount of interconnection and how we can use the pharmacist to try to encourage seniors to allow someone in their home to do an IHE or how we can expose seniors who might not have primary care to a great Oak Street option in their area. Those are the things that we believe we can unlock with the combination of assets.

Oak Street has performed exceptionally well in 2023, despite the pressures in Medicare Advantage. We feel like they are well positioned to perform well in 2024. I'd say there's two things you've got to keep in mind there. We're accelerating the number of clinics, probably 50 to 60 clinics this year versus the original plan 35 to 40. And we'll probably do at the upper end of that range. As you think about the V28 headwinds there, the teams are working to mitigate that down to about a 2% headwind. Could that be 2.5% to 3%? Maybe. But I think they've got a lot of visibility, and you can get that down to that 2% to 3% range, and they're driving towards 2%.

And Signify, one of the other interlinkages, as you think about all of those individual members, we've actually done a fabulous job in using that capability to actually have interactions with that individual population to help return them to care, which is not something that I think we would have unlocked as separate companies.

Question – John W. Ransom: So, UnitedHealth has, in one of our meetings, because we're very persuasive and we get information from people, they mentioned that V28 enterprise-wide was about a $5 billion bad guy, split between Health Plan and Optum Health. You guys have talked about 2% at Oak, getting to 2%, 2.5% maybe from our starting point. But how should we think about the enterprise-wide V28 bad guy for 2024? Or is that not a number you want to share at this point?

Answer – Thomas F. Cowhey: I don't know that I have an equivalent number to share for you. They have a much larger provider business and larger Medicare block than we do with a lot higher market share in duals, for example. But what we have said is that as we look at our Aetna Medicare block, that the V28 headwind is very consistent with the market impact that CMS has talked about. And that may be a function of some of the – we have much lower capitation rates on our Medicare block than others do. We have much lower penetration of duals. And so, we may look more like the general enrollment population than some of our peers.

Question – John W. Ransom: Got you. So, we have one minute. It's amazing. Time flies. Actually, 2 minutes. So, just pivoting quickly to the PBM, two questions there. So, one, if we looked at how PBMs made money 10, 15 years ago versus today, talk about how generally that's evolved, number one. And then, number two, we're noticing recent uptick in rhetoric from some of the start-ups, the rhetoric against the evil PBMs. You guys have lost couple of contracts, nobody seems to like PBMs. Everybody is taking a shot at you. But just talk about how you feel about the defensibility of your large and profitable position in a business that people want to take potshots at?

Answer – Thomas F. Cowhey: I wish that we'd focus as much on the large integrated wins that we've had as we do on some of the ones where we've unbundled because over the last two years, we actually converted two large Blue's plans onto our integrated platform. We offer à la carte services, clients make decisions that they think are in their best interests. As we think about that unbundled versus the bundled, the NPS on the integrated offering is 15% to 20% higher than unintegrated offerings. And so, beyond all the economic benefits, we know that there's a consumer abrasion issue when you don't have a fully integrated product.

And the ones that have been in the press where we've lost the business, we've retained specialty, which tends to be half of the account and one of a good source of profitability across multiple accounts. We feel like we have world-class capabilities. We feel like most of our clients recognize that. We feel good about our traction in the marketplace despite some client losses that have gotten more visibility than perhaps our wins and our momentum has. And we know that as we think about things like GLP-1s and the pressures that they're providing to folks that we can drive net effective cost savings and do the things that our customers employ us to do very effectively.

Well, with that, this is the time for the tepid applause. Fortunately, it's the close of the session.

Thanks everyone.

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