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CVS Health Corp. (CVS)

Q1 2024 Earnings Call

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MANAGEMENT DISCUSSION SECTION

Operator: Hello, and welcome to today's CVS Health Q1 2024 Earnings Conference Call. My name is Jordan and I'll be coordinating your call today. [Operator Instructions]

I'm now going to hand over to Larry McGrath to begin. Larry, please go ahead.

Laurence McGrath

Senior Vice President-Business Development & Investor Relations, CVS Health Corp.

Good morning, and welcome to the CVS Health first quarter 2024 earnings call and webcast. I'm Larry McGrath, Senior Vice President of Business Development and Investor Relations for CVS Health. I'm joined this morning by Karen Lynch, President and Chief Executive Officer; and Tom Cowhey, Chief Financial Officer. Following our prepared remarks we'll host a question-and-answer session that will include additional members of our leadership team.

Our press release and slide presentation have been posted to our website along with our Form 10-Q filed this morning with the SEC. Today's call is also being broadcast on our website where it will be archived for one year. During this call we'll make certain forward-looking statements. Our forward-looking statements are subject to significant risks and uncertainties that could cause actual results to differ materially from currently projected results. We strongly encourage you to review the reports we file with the SEC regarding these risks and uncertainties. In particular those that are described in the cautionary statement concerning forward-looking statements and risk factors in our most recent annual report filed on Form 10-K, our quarterly report on Form 10-Q filed this morning and our recent filings on Form 8-K including this morning's earnings press release.

During this call we'll use non-GAAP measures when talking about the company's financial performance and financial conditions. And you can find a reconciliation of these non-GAAP measures in this morning's press release and in the reconciliation documents posted to the Investor Relations portion of our website.

With that, I'd like to turn the call over to Karen. Karen?

Karen S. Lynch

President, Chief Executive Officer & Director, CVS Health Corp.

Thank you, Larry. Good morning, everyone, and thanks for joining our call today. This morning we announced first quarter results that were burdened by utilization pressures in Medicare Advantage which materially impacted our Health Care Benefits segment. We generated adjusted EPS of \$1.31 which fell short of our expectation. As a result of this performance, as well as our updated expectations for the rest of 2024, we are lowering our full-year 2024 guidance for adjusted EPS to at least \$7. Tom will go through these results and our revised guidance in more detail.

I want to start our discussion this morning by focusing on the challenges we are seeing in our Medicare Advantage business and what we are doing to address these pressures. When we last gave 2024 guidance our outlook assumed normalized Medicare Advantage trends on top of the elevated baseline we experienced in the fourth quarter of 2023. It is now clear that the first quarter 2024 Medicare Advantage trends are notably above this level.

Like others in the industry, our visibility in the quarter was impaired by the cyberattack on Change Healthcare. At the close of the quarter, we established a reserve of nearly \$500 million for claims that we estimated we had not received. This represents our best estimate of missing claims with approximately half of the reserve attributed to our Medicare business.

As we closed the quarter, it became apparent we were experiencing broad-based utilization pressure in our Medicare Advantage business in a few areas. Outpatient services and supplemental benefits continued to be elevated in the first quarter and exceeded our projections. We also saw new pressures in the inpatient and pharmacy category, some of which were seasonal or one-time in nature. April inpatient authorizations and admissions appear to have moderated.

In response to these pressures at a time when we have seen very strong enrollment growth, we implemented a series of actions to ensure our clinical operations are performing at levels consistent with our expectations. We formed multidisciplinary teams to do a retrospective review of our claims data searching for condition specific, geographic, or facility-based outliers as well as to uncover any selection bias in our new and existing membership base. We ensured clinical teams are staffed for current volumes by redeploying nurses from across CVS Health and increasing hiring where necessary. And we evaluated opportunities and implemented actions to optimize our pharmacy benefit spend.

In addition to those efforts, we are accelerating enterprise productivity initiatives to streamline and optimize our operations, ensuring our costs are aligned to the business operations, environment and conditions. We are implementing these actions with speed and urgency, utilizing the broad resources and experience across CVS Health. We have a track record of successfully navigating complex industry pressure and will continue to demonstrate our resilience. We will provide updates throughout the year on these efforts. I also feel it is important to discuss our long-term outlook for Medicare Advantage.

We recently received the final 2025 rate notice, and when combined with the Part D changes prescribed by The Inflation Reduction Act, we believe the rate is insufficient. This update will result in significant added disruption to benefit levels and choice for seniors across the country. While we strive to deliver benefit stability to seniors, we will be adjusting plan level benefits and exiting counties as we construct our bid for 2025. We are committed to improving margins. Despite the recent challenges in Medicare Advantage, we firmly believe the program can remain a compelling offering for seniors and a very attractive business for Aetna and CVS Health over time. Medicare Advantage will continue to deliver significant value to members as well as better outcomes and patient experiences.

Over the next few years, we are determined to improve our positioning in Medicare Advantage. The combination of our internal efforts and the multiyear repricing opportunity gives us confidence in our ability to return to our target margins of 4% to 5% in three to four years. Our top priority in the near term is addressing the pressures faced by our Medicare Advantage business. However, I urge you not to lose sight of the power of our enterprise. The strength and diversity of our business positions us for growth in 2025 as we deliver value to our patients, customers and shareholders. We are ensuring a viable biosimilars market in the US with our Cordavis business which drive lower cost for our customers, savings for consumers and will lead to higher retention and growth.

On April 1, we implemented our unique and meaningful formulary change related to HUMIRA. We have already made a significant impact in the first month since the formulary change dispensing more biosimilar HUMIRA than the entire US market in 2023. This accomplishment truly highlights the combined strength of our CVS Caremark, CVS Specialty and Cordavis businesses to accelerate biosimilar adoption and our commitment to customers to lower pharmacy costs. Our Pharmacy & Consumer Wellness business delivered strong performance this quarter

highlighted by our ability to grow pharmacy share despite softening consumer demand and an uncertain macroeconomic environment. Our CVS Pharmacy locations continue to serve an important and expanding role in communities across the country.

Since we unveiled CVS CostVantage and TrueCost, we have seen a tremendous interest in these more simple and transparent pharmacy models. We are engaged in active discussion with PBMs to rollout CVS CostVantage for commercial contract on January 1, 2025. Additionally, we signed CVS CostVantage agreements with multiple third party discount card administrators that were effective on April 1 and represent more than 50% of all CVS discount card volume. We continue to have constructive dialogue with our partners and look forward to updating you later this year.

In our Health Care Delivery business, we are seeing meaningful progress in our integration efforts. This quarter Signify had the highest volume of in-home evaluations in their history. Oak Street at-risk patients grew nearly 20% over the same quarter last year supported by our ability to utilize touch points across CVS Health. In Aetna, our commercial business had several wins with large group clients with 2025 effective dates demonstrating our ability to deliver integrated benefit solutions with our diversified portfolio of offerings.

In our Medicaid business, we have been successful in several RFPs including Virginia, Michigan and Texas, where our CVS Health assets were highlighted as differentiators. These represent a few recent highlights from across our businesses and demonstrate the value and positive momentum across our broad-based portfolio of assets. The current environment does not diminish our opportunities, our enthusiasm, or the long-term earnings power of our company. We are confident that we have a pathway to address our near-term Medicare Advantage challenges.

While recent results have been pressured, our actions will return our earnings to their appropriate levels and will result in a stronger CVS Health. We remain as committed as ever to our strategy and believe that we have the right assets in place to deliver value to our customers, members, patients and our shareholder.

Tom will provide details on the results of each of our businesses and the components of our updated guidance. Tom?

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

Thank you, Karen, and thanks to everyone for joining us this morning. In the first quarter, our revenues were approximately \$88 billion, an increase of approximately 4% over the prior year quarter. We delivered adjusted operating income of approximately \$3 billion and adjusted EPS of \$1.31. We also generated cash flow from operations of \$4.9 billion, a lower result compared to the same quarter last year primarily due to the timing of Medicare payments. Each of our segments and the enterprise as a whole are focused on executing against their goals and delivering on their financial targets. However, our Health Care Benefits and enterprise results are being materially pressured by the level of Medicare Advantage utilization that we are experiencing. Clearly this is a disappointing result for us.

Let me walk you through some of the drivers and help you understand how we expect them to impact the remainder of the year. In our Health Care Benefits segment, we delivered revenues of approximately \$32 billion, an increase of approximately 25% year-over-year. Medical membership was 26.8 million, up 1.1 million members sequentially reflecting growth in Medicare, individual exchange, and commercial group products, partially offset by the impact of Medicaid redeterminations. Adjusted operating income for the first quarter was \$732 million. This

result reflects a higher medical benefit ratio partially offset by higher net investment income and the impact of favorable fixed cost leverage due to membership growth.

Our medical benefit ratio of 90.4% increased 580 basis points from the prior-year quarter primarily reflecting higher Medicare Advantage utilization, the premium impact of lower Star Ratings for payment year 2024 and unfavorable prior-year development as compared to the prior year. Digging into the drivers of Medicare Advantage cost trends we saw meaningful increases in utilization. We continue to see elevated trends in the same categories we discussed at the end of 2023, including outpatient and supplemental benefits, categories that appeared to be moderating earlier in the quarter, but which completed at levels that in some cases exceeded expectations. Adding to the outpatient and supplemental benefits pressure, we saw new pressures emerge from inpatient categories; RSV vaccines and other pharmacy benefits. Inpatient admits per thousand in the first quarter were up high single digits versus the first quarter of 2023.

While a portion of this increase was anticipated because of the implementation of the two-midnight rule, this result meaningfully exceeded our expectations for the quarter as inpatient seasonality returned to patterns we have not seen since the start of the pandemic. In our Medicaid business, we experienced medical cost pressures largely driven by higher acuity from member redeterminations. We are working closely with our state partners to ensure the underlying trends are reflected in our rates going forward. Medical cost trends in our commercial business have not shown the same pressures we are experiencing in Medicare. Inpatient bed days are favorable to expectations although higher than prior years. Mental health and pharmacy trends remain elevated, but overall performance of the commercial block is consistent with our projections.

Individual exchange medical costs are elevated, but are consistent with projected membership mix and lower revenue payables in 2024. Our individual exchange business remains on target to achieve its profit goals this year. We will continue to monitor both of these blocks closely, but their performance to date is consistent with our prior projections. Days claims payable at the end of the quarter were 44.5 days, down 1.4 days sequentially. This decrease is primarily driven by the impact of membership growth and higher pharmacy trends which tend to complete quicker and reduce DCP as well as other typical seasonal items. Premiums and reserves both grew sequentially approximately 20%.

As a reminder, DCP is an output of our reserving process and overall we remain confident in the adequacy of our reserves. In early April, we saw multiple days of high paid claim activity, which is consistent with the restoration of Change Healthcare and the associated backlog from that disruption. While the final impact of the Change Healthcare disruption will not be known for several months, our most recent interim reporting suggests that our March 31 reserve balances are stable and could show modest levels of positive development, which is not incorporated into our current outlook.

Our Health Services segment generated revenue of approximately \$40 billion, a decrease of nearly 10% year-over-year primarily driven by the previously announced loss of a large client and continued pharmacy client price improvements. This decrease was partially offset by pharmacy drug mix, growth in specialty pharmacy and the acquisitions of Oak Street Health and Signify Health. Adjusted operating income of approximately \$1.4 billion declined nearly 19% year-over-year primarily driven by continued pharmacy client price improvements, lower contributions from 340B and the previously announced loss of a large client. This decrease was partially offset by improved purchasing economics. Total pharmacy claims processed in the quarter were nearly 463 million and total pharmacy membership as of the end of the quarter was approximately 90 million members.

We continue to drive growth in our Health Care Delivery assets. Signify generated revenue growth of 24% compared to the same quarter of last year. Oak Street ended the quarter with 205 centers, an increase of 33

centers year-over-year. We continue to expect to add 50 to 60 centers in 2024. At-risk members at Oak Street ended the quarter at 211,000, an increase of 34,000 year-over-year. Oak Street also significantly increased revenue in the quarter, growing over 25% compared to the same quarter last year.

In our Pharmacy & Consumer Wellness segment, we generated revenue of approximately \$29 billion, reflecting an increase of nearly 3% versus the prior year and over 5% on a same store basis. Drivers of this revenue growth in the PCW segment included increased prescription volume with increased contributions from vaccinations, as well as pharmacy drug mix. These revenue increases were partially offset by the impact of recent generic introductions, continued reimbursement pressure, a decrease in store count and lower contributions from OTC test kits. Adjusted operating income was approximately \$1.2 billion, an increase of approximately 4% versus the prior year driven by increased prescription volume, improved drug purchasing and lower operating expenses, including the impact of store closures.

These increases were partially offset by continued pharmacy reimbursement pressure. Same store pharmacy sales were up over 7% versus the prior year and same store prescription volumes increased by nearly 6%. Same store front store sales were down by about 2% versus the same quarter last year, but up 1% when excluding OTC test kits. As a reminder, the public health emergency was still active during the first quarter of last year.

Shifting to liquidity and our capital position. First quarter cash flow from operations was \$4.9 billion. We ended the quarter with approximately \$1.9 billion of cash at the parent and unrestricted subsidiaries. In the first quarter, we returned \$840 million to shareholders through our quarterly dividend. We also completed our \$3 billion accelerated share repurchase transaction, retiring approximately 40 million shares in the quarter. We do not expect to repurchase any additional shares for the remainder of 2024.

Our leverage ratio at the end of the quarter was approximately 4 times. This leverage ratio was higher than we expect to maintain on a normalized basis. We remain committed to maintaining our current investment grade ratings.

Turning now to our full year outlook for 2024. As Karen mentioned, we revised our 2024 adjusted EPS guidance to at least \$7 to reflect our first quarter results, as well as our updated expectations for the remainder of 2024. In our Health Care Benefits segment, we now expect adjusted operating income of at least \$3.6 billion, down from our previous guidance of at least \$5.4 billion. We now expect our 2024 medical benefit ratio to be approximately 89.8%, an increase of 210 basis points from our previous guidance.

In the first quarter, Health Care Benefits medical costs primarily attributable to Medicare Advantage came in approximately \$900 million above our expectations. If we break that down further, we estimate that roughly \$500 million of that variance is specific to the quarter or season, including the larger than expected impact of seasonal respiratory and RSV costs and return to inpatient seasonality patterns that look much more like pre-pandemic periods.

As Karen mentioned, early indicators for April inpatient authorization support our current seasonality projections and the return to pre-COVID patterns. We've also raised our expectations for RSV related costs in the second half based on our experience in the first quarter. The remaining approximately \$400 million of medical cost pressure in the first quarter is driven by elevated utilization trends that our guidance now assumes will persist for the remainder of 2024. The primary drivers of this projected variance include outpatient service categories, such as mental health and medical pharmacy, as well as supplemental benefits such as dental. Partially offsetting some of this pressure is better than expected volumes, expense management and increased net investment income,

which together are expected to contribute approximately \$500 million more than we assumed in our previous full year guidance, with roughly half of this offset occurring in the first quarter.

In our Health Services segment, we are updating our estimate for 2024 adjusted operating income to at least \$7 billion, a decrease of approximately \$400 million. The majority of this adjustment is attributable to Health Care Delivery, predominantly in our CVS Accountable Care business driven by Medicare utilization and some out of period pressure. We also saw some modest utilization pressure at Oak Street during the quarter and are including the provision for higher trends for the remainder of the year in our updated guidance. The remainder of the pressure is in our other businesses in the Health Services segment primarily driven by volume and mix trends and the associated impact on our ability to deliver on network and client guarantees.

Our expectations for the Pharmacy & Consumer Wellness segment remain the same, with adjusted operating income of at least \$5.6 billion. This outlook incorporates a cautious stance on consumer activity over the remainder of the year due to slowing front store activity in the first quarter. We now expect 2024 share count to be approximately 1.265 billion shares and our adjusted tax rate to be approximately 25.6%.

Finally, we updated our expectation for cash flow from operations to at least \$10.5 billion in 2024. You can find additional details on the components of our updated 2024 guidance on our Investor Relations webpage. We plan to share more detailed 2025 guidance later this year, but in an effort to help investors build reasonable expectations for next year, we wanted to share some preliminary thoughts on our outlook. Within Health Care Benefits, our Medicare Advantage business is projected to generate between \$65 billion and \$70 billion in revenues in 2024, but will experience significant losses.

We are committed to driving meaningful improvement in our Medicare Advantage margins in 2025. Given our projected baseline performance, 2025 will be the first step in a three to four-year journey to get back to our target margins of 4% to 5%. Improved Star Ratings in 2025 could represent a \$700 million tailwind depending on membership retention levels, but also reduces our ability to adjust certain benefits. The remainder of our margin improvement in 2025 will be a function of pricing actions in an environment where we are facing headwinds from an insufficient rate notice and prescription drug coverage changes that substantially increase plan liability. We will take material pricing and benefit design actions for 2025 and the impact of those changes will depend on how cost trends develop in both 2024 and 2025 and how the market responds to those trends.

In Health Care Benefits other business lines, we are building strong momentum. We're planning for another year of margin progression in our individual exchange business. We've seen success in the group commercial selling season this year and we're recently awarded several key Medicaid RFPs. In our Health Services segment, early progress of our Cordavis business is encouraging and supports our innovative approach to the biosimilar opportunity driving differential savings for our PBM customers. In our Health Care Delivery business, we are committed to improving margins in CVS Accountable Care. Oak Street's margin trajectory will be supported by meaningful patient enrollment and a realignment of Medicare Advantage benefits as the market adjusts to elevated utilization.

Signify continues to show impressive growth and is building momentum into 2025. We have received a strong early reception to our new pharmacy model, which creates potential for outperformance in our PCW segment. As Karen mentioned, we are accelerating multiyear enterprise productivity initiatives to streamline and optimize our operations. Finally, our framework contemplates a stable share count in 2025. While many uncertainties remain that could drive a wide range of outcomes including our 2024 baseline performance and the potential that medical cost trends subside as compared to our current outlook, at this distance our goal remains to deliver low double

digit adjusted EPS growth in 2025. Our team remains committed to executing against opportunities to outperform this guidance.

With that, we'll now open the call to your questions. Operator?

QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] Our first question comes from Justin Lake of Wolfe Research. Justin, please go ahead.

Justin Lake

Analyst, Wolfe Research LLC

Q

Thanks. Good morning. Couple questions here. First on the cost trend in the first quarter. Would like to get some more detail on the \$500 million that you said is in Q1 that's not going to reoccur, right? I think everyone would like to get comfort that this \$7 is a baseline that we can be comfortable with. So, if that's not reoccurring, can you just walk us through what the moving parts are there? For instance looks to me like your PYD was 200 million below the last couple years. Maybe that's a big part – that's clearly a big part of it. How much was RSV? Any other moving parts? Anything you could do to get us comfortable that that \$500 million is seasonal would be a good start?

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

A

Hey, Justin, it's Tom. So, the largest impact within the quarter is the seasonality adjustment on inpatient, and as I noted in the prepared remarks, our April authorization data supports our updated seasonality projection as we did experience some negative prior year development in the quarter and that is clearly part of the \$500 million. But as you look at where that occurred, that was really in some of our inpatient categories, where the trends we stated negatively. And so you saw the beginning of that uptick, you saw an uptick again January admits were higher than our expectations, February was improved versus January, March was improved versus February. And so we've seen really a – we saw a spike earlier in the quarter, which really started in hindsight in the fourth quarter. And as you look at that pattern, it very closely resembles what we would have seen in a 2018, 2019 period trended forward. And so that gives us a lot of comfort as we look at both what we're seeing now versus what the historic patterns pre-COVID look like that a lot of this was actually seasonal. So if you take out the prior period development, you also had some provider liabilities that were settled inside the quarter. As we did have some policy liberalizations that took place inside the quarter, I mean, they've been reinstated since the quarter end. So that should not be an ongoing impact. And then there were some other one-time impacts including the initial reserve build for some of our new membership growth that would be incorporated inside that \$500 million. We also as you noted we did see some RSV in the quarter. We did make revision for some of those costs of the \$500 million to occur in the back half of the year, but we're not projecting that the vast majority of those costs are going to be part of the run rate, unlike the \$400 million that we're pulling through.

Justin Lake

Analyst, Wolfe Research LLC

Q

Got it. And then just some color on the Medicare Advantage margin and improvement and any offset. So, right now, looks like if I estimate your MA margins, I was thinking minus 3%, minus 4% negative. Is that the right ballpark, how much of an improvement, you said material improvement. That would seem you've got a couple hundred basis points there, by my estimate that's \$0.70, \$0.80 alone. So can you talk us through how much

improvement, what you think is material to get back that trajectory to the over 3 to 4 years and anything that would be an offset there? Any kind of one-time benefits this year like bonuses, things like that, that would work against it would be helpful. And I'll jump back in queue. Thanks.

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

A

Justin, great question. So as you think about Medicare Advantage, as I said it's a \$65 billion to \$70 billion revenue portfolio today. And our goal for next year is that we would get about 200 basis points of margin improvement in that business or up to that amount and we obviously haven't finalized our bids yet. You're in probably the right ZIP code as you think about what the margin is on the medical – implied margin is on the Medicare business as you think about that business. We talked last quarter about the fact that it was going to be breakeven in our current projections and we lowered the guidance on Health Care Benefits by \$1.8 billion, and said the majority of that is related to Medicare. So we've given you all the pieces to kind of understand why we think it will lose a significant amount of money this year. But as you think about improvement there, obviously there's a lot of work that we still need to do to understand what benefits we're going to adjust and what ones we can and can't. Our Stars is a tailwind, but also impacts our ability to adjust, because it lowers our TBC availability on that national PPO contract. And maybe Brian, do you want to give a little bit of color of how you're thinking about bids and margin improvement?

Brian A. Kane

Executive Vice President & President-Aetna, CVS Health Corp.

A

Sure. Thanks, Justin. So I would talk about 2025 in terms of headwinds and tailwinds. Let me just walk through those. So, obviously we have very significant high trend that we are absolutely going to incorporate into our pricing. So the trends that Tom talked about for 2024 we will reflect again in 2025. So that's clearly a headwind. But we're not going to miss on trend. We've talked in the past about the Part D changes, which is a really important element here and there's really two elements of that. One is that the benefit has been enriched pretty significantly by the IRA. And then secondly the plan is on the hook for greater liability in the catastrophic layer, in that we get less reinsurance than we used to. And so we intend to price for that and be very thoughtful around that. Third, as we – as Karen mentioned in her remarks, the rates that we received were clearly disappointing and not sufficient to make up the trend pressures and IRA pressures that we're seeing. And then finally as Tom mentioned around TBC, that's clearly a limitation that we need to be focused on. It's focused on general enrollment block. It does not apply to DSNPs and it does not apply to certain supplemental benefits as well, which we'll be very focused on and make sure we rightsize for 2025 pricing.

As we think about tailwinds though, Tom mentioned the Stars tailwind, which is about \$700 million assuming a stabilized membership and I'll come back and talk about that a little bit. With respect to the pricing actions, we're going to be very focused on taking those pricing actions as I mentioned to incorporate the trends, but also be mindful of how we think about TBC. Stars does impact TBC in that it reduces the amount of allowance we have under the regs. But as I mentioned, there are opportunities we have to trim benefits around TBC and we'll be very focused on doing that. On the DSNP product our intention is to reduce our supplemental benefits in certain areas, including some of the Flex cards that we put in the market this year and so you'll see us reduce those benefits and that allows us to capture margin without impacting TBC and so that's important.

The other point I'd make and Karen and Tom alluded to it, we will be taking actions around certain service areas. So to the extent that we don't believe we can credibly recapture margin in a reasonable period of time, we will exit those counties. We will also be looking at areas where we believe that it makes sense to actually discontinue a specific product than reintroduce a new product, where TBC won't apply and we'll be looking at those opportunities as well, being mindful of the member disruption and some of the churn that you might see. And so

as we step back, we're very focused on margin, margin over membership. Obviously we're trying to create a stable book with respect to our membership, and as we think about the membership impacts, I think, there are several things that go into that calculation. One is, we believe there will be significant disruption in the PDP market and the Med Supp market. We're going to see prices go up. We're going to see people exit certain plans and we know prices are increasing on Med Supp. And so that will be a tailwind to our membership projections. Offset by the fact as I mentioned – as we've all mentioned that we're going to be taking significant pricing actions and really it's going to depend on what our competitors do. We believe that they're rational. We believe they're seeing similar-type trends and so they're going to price as well for some of these pressures, but that's something that we'll have to calibrate as we get into pricing, and as I mentioned, there will be some service area reductions. But again the focus is on margin over membership. If there's a membership reduction it's relatively small impacts on margin and we're focused on making sure we price this product appropriately for 2025 and beyond.

Karen S. Lynch

President, Chief Executive Officer & Director, CVS Health Corp.

A

Yeah. Justin, I'm just going to reiterate what I said in my prepared remarks. We are committed to improving margin in Medicare Advantage and we will do so by pricing for the expected trends. We will do so by adjusting benefits and exiting service counties. And we are committed to doing that.

Operator: Our next question comes from Lisa Gill of JPMorgan. Lisa, please go ahead.

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Q

Thanks very much. I just want to follow up on a few things that you said. Brian, I want to go back to your comment around membership and your expectation that the decline in Medicare Advantage membership could be small. Is that based on assumption that what the pressure we're feeling is for everybody in Medicare Advantage and that therefore everyone will readjust and again to Karen's point you'll look at certain counties and adjusting certain plan levels, so you could lose some membership, but you're not expecting a large membership decline as you think about 2025 just with the increased cost and changing benefits, et cetera? I just want to make sure I understand that to start.

Brian A. Kane

Executive Vice President & President-Aetna, CVS Health Corp.

A

Sure. And thanks for the question, Lisa. So, I would say there are two elements to this, what's going to happen from an industry perspective in growth and then what we at Aetna are going to do. So on the industry side, as I mentioned, I think, there are some clear tailwinds from the perspective of what's going to happen in the traditional fee for service market, i.e. PDP and Med Supp, and so as members, potential members are evaluating their choices they're going to have to take a look at what are the price increases and some of the disruption that's going to happen in the traditional fee-for-service market. So that's – that would be a tailwind. I do think though that the industry broadly is going to be trimming benefits and in some cases significantly and exiting from certain counties that aren't profitable. I think that's an industry issue and I think it's clearly an Aetna focus as well. And so how that calibrates where we ultimately end up on membership is something that again we've got to work through bids and pricing to sort of estimate what we think our competitors are going to do. So, it's hard to say right now that we won't have a meaningful decrease in membership. It's certainly possible. What – the message we're trying to communicate is we're focused on margin over membership and to the extent that we do have a larger than desired membership reduction then that will occur and we'll focus on the margin side. But again I think our competitors here are rational. I think, they are facing a number of similar pressures. Obviously, we have our own

unique elements that we need to address as well. And so I think that calibration as well as what happens to the broader industry will really dictate where membership goes next year.

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

Lisa, from a very high level ...

A

Lisa C. Gill

Analyst, JPMorgan Securities LLC

I understand ...

Q

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

Hey, Lisa. Just – as you – from a very high level as you think about what the impact of membership loss is, just think about the comments that we made about margin restoration relative to the implied losses in the book. And so losing additional members doesn't necessarily contribute to lost profit in 2025.

A

Lisa C. Gill

Analyst, JPMorgan Securities LLC

And then, Tom, if I can just understand the cadence of 2024, and you – obviously you talked about low double-digit growth in 2025. How do we think about that cadence as we're continuing throughout 2024? Anything you'd specifically call out as we think about the rest of 2024?

Q

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

Yeah. One of the things that I think is worth talking a little bit about as you think about the Health Services segment, we do have some pressures in there that we think are Medicare market related in the Health Care Delivery business. We also saw some timing and mix-related impacts in our other Health Services segment businesses. And we've taken a cautious stance right now on in-year recovery on those. And that's because we lost a large client there. We had some insourcing activity at another large client. We've had some supply shortages in some other categories. We also delayed the initial launch of our biosimilar product to April 1 from our initial plans. So accordingly, as we look at the seasonality of earnings, we think we currently expect that you'll see probably more like 55% to 60% of our earnings in the second half of 2024 to adjust for some of that sloping.

A

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Okay. Great. I'll stop there. Thanks.

Q

Operator: Our next question comes from Nathan Rich of Goldman Sachs. Nathan, please go ahead.

Nathan Rich

Analyst, Goldman Sachs & Co. LLC

Great. Good morning and thanks for the questions. I just wanted to follow-up on some of the drivers for 2025. I guess from this point in the year, I mean, can you talk about how big of a shortfall the final rate was relative to what your current view of kind of cost trend will be for 2025? And then how are you thinking about the change in profitability for the Part D business next year in light of the benefit design changes that you've talked about?

Q

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

A

The – I might leave it to Brian to talk about the Part D changes and their impact on profitability. There is a very substantial change in plan liability there, which will result in much higher premiums, which we think is going to impact both overall benefits within the bids, but also as we think about those seniors that are currently in the market to purchase a bundle that the cost of that bundle is going to rise pretty dramatically for them, which may even with a less robust set of benefits make Medicare Advantage an attractive option in 2025.

The bid itself for 2025, the – what we received from CMS, the pricing was just disappointing. It's clearly as we look at our trends, as we look at the market trends, we don't think that the rate sufficiently reflects that. We have another year of the phase-in of the risk adjustment model. There's no flexibility that's been given to date on TBC despite the material changes that we are experiencing, the cost of The Inflation Reduction Act on Part D. And so the combination of those things just makes a tough year for 2025 pricing harder when we don't see the pull-through of what most of the market participants are experiencing into the bid baseline. And Brian maybe talk a little bit more about that.

Brian A. Kane

Executive Vice President & President-Aetna, CVS Health Corp.

A

Sure. I mean, first with respect to Part D, I think, Tom articulated it well. There's this incremental benefits that are being offered and significant increase in plan liability. And while there will be an increase in direct subsidy and we're expecting that, it really isn't sufficient to cover that increased liability that the plans have. And so there's going to be a lot of discussion I imagine in the industry certainly here at Aetna about what product is ultimately viable for us as we think about the potential risks and volatility that could result from putting out a product.

And the impact of potential adverse selection in terms of who you attract, the types of members you use, brand utilizers, specialty utilizers, et cetera, creates additional uncertainty particularly because of that enhanced liability and the fact that the benefits are so rich that typical traditional views of insurance and getting low price and those sorts of things may or may not apply in the same ways it did. So those are the types of things we're thinking through. And obviously as we come back on the next quarter call we'll give you more color about our perspective on the Part D market. We do think there's going to be disruption.

We do think it's going to necessitate premium increases and that's why there's just some uncertainty about where the ultimate industry goes from an MA perspective in terms of membership. With respect to your first question on the trend delta, look, it's obviously very significant. We've been very clear that the trends we're seeing in 2024 which are really consistent with 2023 we expected some measure of break to a more normalized trend as Karen and Tom said.

And frankly, I think, we were conservative on what a normalized trend would be. If you go back historically even before the pandemic for many, many years trends were in the 3% to 5% range. We saw trends in 2023 approaching 10%. We're seeing trends in 2024 mirror those levels. Exacerbated even more so by some of the seasonal factors that Tom mentioned in the first quarter. And so we're going to continue those trends into 2025.

Now we have really not seen two years let alone three years of those levels of elevated trends without break, but it's imperative that we include that in our pricing and we intend to do that and our expectation is our competitors will be thinking about it in a similar fashion. And so we need to think hard about how we're going to make up that delta between what we got in the pricing and what we got in trend – what we have in trend, and there are a number of levers we're going to pull. Benefits is one that clearly we're going to be focused on.

Nathan Rich

Analyst, Goldman Sachs & Co. LLC

Great.

Q

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

And if I just think about stepping back from your question – as I just think about stepping back from your question, Nate, revenue in that product per member is clearly going to go up. It's just not clear exactly what's going to happen to the overall membership base, but we're going to price for a profitable product and what's ultimately going to be a higher premium product on Part D.

A

Nathan Rich

Analyst, Goldman Sachs & Co. LLC

Okay. Great. And sort of where I wanted to go with the follow-up, you talked, Tom, about the 200 basis points of margin improvement in the MA business next year. So, that's around \$1.3 billion, \$1.4 billion depending on where membership shakes out, and half of that's the Stars tailwind. I think, if we just look at the other \$700 million on the PMPM basis, it's \$10 to \$15 PMPM, but sounds like there maybe some cost headwinds that are maybe offsetting the change in benefits. And so I guess I wanted to just see if you could give us a rough sense of maybe the type of reduction that you're talking about in terms of the benefit design as we think about next year and then what the opportunity would be as we think three or four years down the road.

Q

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

Yeah, Nate, I think, for competitive reasons, I don't want to get into any more than we've already given relative to the improvement or any more granularity there, other than to say, I think, we've made it clear that everything is on the table. So, there are TBC benefits that will probably get adjusted. There are non-TBC benefits that will get adjusted. We'll look at – all – like this is not an acceptable result, where we're going to be for this year in terms of profitability on this block of business, and so we're going to look at everything that we can do to try to improve profits for next year and maintain some level of stability inside the book.

A

As you're doing the bridge between 2024 and 2025, there are some variable expense items that are clearly going to come back in 2025. That's part of the reason that we talked about how we're going to accelerate some of our expense efforts to try to offset any restoration of expense that would come back in 2025. It's a little early days to try to talk about what that will yield in 2025, but we're committed to taking action to help offset any headwinds there. And we'll give you more updates on that as we get to next quarter.

Karen S. Lynch

President, Chief Executive Officer & Director, CVS Health Corp.

Yeah, Nate, I would just add that we continue to evaluate our overall cost structure with respect to operations, process, productivity, and we began a comprehensive review of that last year. We took actions. They're showing up this year and now we're going to accelerate other initiatives over the next few months. And as we continue to size those efforts, we'll update you throughout the year.

A

Operator: The next question comes from Stephen Baxter of Wells Fargo. Stephen, please go ahead.

Stephen Baxter

Analyst, Wells Fargo Securities LLC

Q

Hey. Another follow-up on Medicare Advantage. Thank you. You mentioned in prepared remarks that I think you spent time looking for potential selection bias either with new members or inside of your existing book. I'm not sure if you talked about what you actually found when you did that. But just trying to understand whether you saw greater than expected switching from your own members or if the step-down in profitability across the broader book was mirrored in your new membership or maybe that was something in excess of that to consider. Thank you.

Brian A. Kane

Executive Vice President & President-Aetna, CVS Health Corp.

A

Yeah, so we've looked at it very closely as you can imagine trying to understand whether the new members are creating disproportionate impact on our results. And we've analyzed it every which way we can, and when you look at basic results such as their admissions per thousand or their pharmacy spend or their risk score or other categories of care, we're really not seeing a material difference between the new members and the old members. And so what we're really seeing is a pressure on our entire book that we are having to take action against ultimately. We looked at things of course and I know there's been a lot of discussion around the fitness benefit for example. That was clearly something that was appealing to our members on a general enrollment block. It's just on the general enrollment block.

In terms of selecting that benefit. When we look at the financial impact of that, actually it's pretty modest. It's actually running in line with our pricing expectation. Some of the dental benefit enrichment that we did we are seeing some pressures as Tom mentioned on that supplemental benefit. We are seeing more members use that benefit and use more of it. And so but that's really across the book. And so again, I don't see a selection bias between old and new members. But rather pressures throughout that we need to address for 2025.

Operator: The next question comes from Michael Cherny of Leerink Partners. Michael, please go ahead.

Michael Cherny

Analyst, Leerink Partners LLC

Q

Good morning. And thanks for taking the question. Maybe I'll stick to Health Services for a second. I'm sure others will come back to other MA questions. But as you think about the performance in the quarter and the dynamics you're seeing about prepping both for changes in members, changes in the customer losses, in terms of the large customer roll-off, how do you think about the scaling dynamics of your purchasing capabilities and how that's ramping into Cordavis, as you've launched that and I guess, you gave us an early look there, but are there any additional signs you can give us on how you think about the financial contribution of Cordavis baked into either this year's guidance or in terms of the targets for next year?

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

A

There is a contribution from Cordavis that's embedded in our Health Services guidance. We haven't disclosed to date, Michael, what that impact is other than to say versus our initial projections because we delayed the formulary change to 04/01, we had hoped to do it a little earlier in the year. I mean, that did have a little bit of a timing impact inside the quarter, but the adoption there has been fabulous. The client reception has been fabulous. And maybe, David, you can talk a little bit more about what you're seeing there.

J. David Joyner

Executive Vice President & President-CVS Caremark, CVS Health Corp.

A

Sure. Thanks, Tom. And before I get into the actual results for the biosimilar change, maybe I'll just spend a second talking more broadly about the question you asked around control and kind of our confidence on the ability to continue to have purchasing advantages in the market. So I go back to the strength that we have in specialty. So most of all the success we've delivered is because of our leadership position specifically in the specialty marketplace. So we have unmatched access both across mail, retail, and the home infusion space. We have broad set of products both in the pharmacy and the medical benefits side. Continue to be a leader in the limited distribution category. Continue to be a leader in the new developing cell and gene therapy marketplace.

So that combined with the technology that we've invested has allowed us to be kind of the leading provider in the space. So that is the foundation, allowed us to have the confidence to make the change for the formulary position on April 1. So, if you look what was mentioned in the prepared remarks, we've actually had a change as of 04/01 removing HUMIRA from the formulary and replacing it with a low list priced biosimilar. And as we said earlier, in just three weeks' time, we've actually surpassed all of the biosimilar volume in all of 2023. So that's – we've been able to hit what is important in terms of control and towards the purchasing, which is that we've been able to migrate more than 90% of the volume in the first month.

And then when you look specifically inside the CVS Specialty Pharmacy where we had a set of new services around technology, access to the prescribers and the members we've been – we've actually had a 94% conversion rate. So it's a really powerful outcome. And I think, it speaks to obviously the strength of our business. And as that translates into savings for our customers, we had mentioned that we're delivering a 50% savings on the 2022 run rate for this drug and then as you translate that into the member benefits because we've actually moved to a low list price product and we've actually had clients adopt what we'd call an intelligent benefit design, we've been able to have 80% of the members with a zero dollar out of pocket.

So again, I think, if you look at what we've done, it's a clear win for our clients, our patients, and we've also made a considerable investment in the durability of the biosimilar market. So I think all of that then contributes to the question you originally asked which is size and scale really is generally driven and what I would believe is the strength in our purchasing economics is the ability to control and move market share. And again, this is another evidence and growth marker that we help to continue down that path.

Karen S. Lynch

President, Chief Executive Officer & Director, CVS Health Corp.

A

Yeah. Mike, I would just say on the biosimilar obviously it represents one of the biggest opportunities to reduce overall pharmacy costs for the US health care system. As you know, it's \$100 billion market by 2030 and as you can see in the very first few weeks of our launch, we've had incredible adoption and we continue to evaluate the pipeline of opportunities. So, we are excited about the potential and the future of the biosimilar market.

Operator: Our next question comes from Josh Raskin of Nephron Research. The line is yours.

Joshua Raskin

Analyst, Nephron Research LLC

Q

Hi. Thanks. Good morning. Here with Eric as well. So my question is that – well, first just numbers question. The \$400 million in Health Care Services guidance reduction, how much of that is specifically Oak Street? And then on the MA I hear still committed to 4% to 5%. The journey starts in 2025. That's very, very clear. How much of your membership is in counties that you are contemplating exiting? Just sort of wholesale leaving of the market?

And then also how does the repricing of MA fit into your overall enterprise strategy as obviously lots of your assets sell into that channel as well?

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

A

Let me start with the HSS question, Josh, and then we can try to get to the other one. So as you think about HSS, so we took it down by about \$400 million, the majority of that reduction is the Health Care Delivery business. And the largest driver in there is unfavorability on CVS Accountable Care that came through in terms of the savings rate, which is driven by Medicare utilization and that includes an out of period charge that was taken in the first quarter that's embedded in there. I'd say the remainder of that piece of a piece is really Oak Street, but as we think about the first quarter, the performance in that business was reasonably good, and so as we think about what we've seen in the broader market, we made a provision that perhaps some – there could be some lag there in our forward outlook. We'll obviously have to see how that ultimately develops.

As you think about 2023, the business did an excellent job of navigating some of the broader headwinds interplays with some of their new clinical programs and how they played out over the course of the year. We're hopeful that we could see some favorability to that number over time, but we have to see how that all manifests itself in the results.

Mike, I don't know, anything else you would add?

Michael T. Pykosz

Executive Vice President & President-Health Care Delivery, CVS Health Corp.

A

Yeah. Tom, I think you summed it up well from a financial perspective. And the thing I would add, when I think about Health Care Delivery more broadly and specifically Oak Street is for the rest of 2024 and really in 2025 and beyond I think there's a huge opportunity that Brian and I are working really closely on, on how do we leverage the quality of care and the ability to really bend the cost trend and drive MLR improvements, how do we leverage that more broadly across Aetna with Oak Street. And so there's a lot of things we're doing both from adding membership from Aetna to Oak Street centers but also leveraging some of the out of center capabilities we have around transitions programs and care in the home that we use for Oak Street today, and let's use that for an Aetna member. So, I think, we have a lot of opportunity here that we'll see play through in the coming years.

Brian A. Kane

Executive Vice President & President-Aetna, CVS Health Corp.

A

And I'd just add to Mike that, as he said, we are working very closely together. For example, while obviously we're not going to provide color today on specific counties and the extent which counties we'll exit, we wouldn't do that in an Oak Street footprint as an example, right. So we're going to be very thoughtful about how we trim our book with the goal of over time retaining the margins and attaining the margins that Tom articulated. I'd also remind you that every 100 basis points is worth more than \$500 million on a trend basis and so when you think about where historical trends have been, if you think about where trends are today, we're in no way baking this into our assumptions, but as you think about recovery here, this has the potential to bounce back and retain those – get back to that profitability as well, which I think is important to mention. But we're going to be very thoughtful about how we think about our membership footprint. And again, the ultimate goal is membership stability, but we're going to favor margin over membership for next year.

Operator: Our next question comes from Elizabeth Anderson of Evercore ISI. Elizabeth, please go ahead.

Elizabeth Anderson

Analyst, Evercore ISI

Q

Hi, guys. Good morning. Thanks for the question. I was wondering can you talk about sort of care management tools and sort of the impact that you're thinking about in terms of their impact on 2024 and then any sort of changes you're making in 2024 that you think will have an impact as we think about the 2025 results for HCB? Thank you.

Michael T. Pykosz

Executive Vice President & President-Health Care Delivery, CVS Health Corp.

A

Well, clearly care management is an important tool that we use to engage our members and we spend a lot of time segmenting, who our high risk members are, who are the members who would benefit most from care management. We're actually using a lot of really advanced AI tools to identify those members. We really think we have excellent analytics to be able to pinpoint who those members are and how are we best able to engage with them. More the types of things that will get them to engage with us and then also make it easier for our care management nurses at the point of care to be able to provide the level of advice and support that a member needs. And so, it's something that we're very focused on.

I would tell you that we continue to roll out some of these AI capabilities that makes these programs much more effective with much better ROIs and so while there will be modest impacts in 2024 over time we expect that to be a differentiator for us, and so we're very focused there.

Brian A. Kane

Executive Vice President & President-Aetna, CVS Health Corp.

A

I would just add to that. This is where a partnership with Health Care Delivery and Aetna comes in. Between Signify and some of the capabilities we have at Oak Street, there's a lot of boots on the ground in market capabilities that we have to really change the health trajectory of patients whether that be readmissions to the hospital or managing your most complex chronic patients, and so this is where I think a lot that partnership plays out is in that space of getting a deeper level of impact, because we have the resource, we have the programs, we have the know-how, now we can extend those over a lot more members. And so I think both Signify and Oak Street will bring a lot to the table over the coming years on how we can really bend that cost trend.

Operator: Our final question comes from Ann Hynes of Mizuho Securities. Ann, please go ahead.

Ann Hynes

Analyst, Mizuho Securities USA LLC

Q

Great. Thanks. You talked about Pharmacy Services. There was some pressure on mix and also your inability to make prior guarantees. Can you just elaborate on both comments? Is the prior guarantee a diabetes issue given the GLP class? Thanks.

Thomas F. Cowhey

Executive Vice President & Chief Financial Officer, CVS Health Corp.

A

It's not a diabetes issue. Think of it as the – we have to have projections about what the mix looks like to ensure that we appropriately hit all of our client guarantees. And with the changing mix inside the quarter given some of the disruptions that we saw, not only with the loss of a large client, but with the in-sourcing of another client's business and some of the disruptions in the marketplace in terms of volumes specifically GLP-1s was part of that. We were – we missed our guarantees by a little bit. We'll see how we're able to recoup that over the remainder of

the year. But at this point, what we've assumed is that that first quarter is permanent and that we can get back to our previous projections for the remainder of the year.

David, anything you'd add to that?

J. David Joyner

Executive Vice President & President-CVS Caremark, CVS Health Corp.

A

No, I think, that's consistent with the way we see it. I will just add one thing on GLP-1s. Obviously, it's – there's been a lot of volatility. One, because of supply constraints that we've experienced and obviously a lot of work-around managing what we would see as just unprecedented demand combined with very challenging price point is leading to a lot of energy around how to best manage this category, through whether it be formulary, more aggressive utilization management, and the broader care management wrappers on this. But this category alone is driving obviously significant cost for our clients and it's also driving significant expense within our organization just to support what is now one of our highest drivers of call volume around people trying to find access to the product and making sure that we get consistent supply in the market.

So we believe we've got a really strong set of programs and services to manage the category, and we believe once there's competition and adequate supply, we'll be able to have more consistency around how we manage this category.

Karen S. Lynch

President, Chief Executive Officer & Director, CVS Health Corp.

As we close the call, I want to take this opportunity to thank our colleagues for their many contributions and we look forward to providing you updates throughout the year. Thank you for joining the call today.

Operator: Ladies and gentlemen, this concludes today's call. Thank you for joining. You may now disconnect.

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