

07-Feb-2024

CVS Health Corp. (CVS)

Q4 2023 Earnings Call

CORPORATE PARTICIPANTS

Laurence McGrath

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

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

Brian A. Kane

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

Prem S. Shah

Executive Vice President, Chief Pharmacy Officer & President-Pharmacy and Consumer Wellness, CVS Health Corp.

Michael T. Pykosz

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

OTHER PARTICIPANTS

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Justin Lake

Analyst, Wolfe Research LLC

Kevin Caliendo

Analyst, UBS Securities LLC

Nathan Rich

Analyst, Goldman Sachs & Co. LLC

Ann Hynes

Analyst, Mizuho Securities USA LLC

Joshua Raskin

Analyst, Nephron Research LLC

Elizabeth Anderson

Analyst, Evercore ISI

Stephen Baxter

Analyst, Wells Fargo Securities LLC

Allen Lutz

Analyst, BofA Securities, Inc.

Charles Rhyee

Analyst, Cowen & Co. LLC

John W. Ransom

Analyst, Raymond James & Associates, Inc.

Erin Wilson Wright

Analyst, Morgan Stanley & Co. LLC

MANAGEMENT DISCUSSION SECTION

Operator: Good morning or good afternoon, all, and welcome to the CVS Health Q4 2023 earnings results call. My name is Adam, and I'll be your operator today. [Operator Instructions]

I will now hand the call to Larry McGrath to begin. So, Larry, please go ahead when you are ready.

Laurence McGrath

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

Good morning, and welcome to the CVS Health fourth quarter and full year 2023 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-K 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 Form 10-K we filed this morning.

During this call, we'll use non-GAAP measures when talking about the company's financial performance and financial condition, and you can find a reconciliation of these non-GAAP measures in this morning's press release and in the reconciliation document posted to our 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, CVS Health Corp.

Thank you, Larry. Good morning, everyone, and thanks for joining our call today.

In 2023, we made strong progress on our journey, bringing together integrated health solutions that meets the needs of consumers where and when they want health care. We successfully navigated a challenging environment and delivered on our financial commitments, a powerful testament to the strength of our diversified company. We are building America's health platform, enabling access to high-quality, convenient and affordable care that supports individuals in building healthier lives.

In the fourth quarter of 2023, we delivered adjusted operating income of \$4.2 billion and adjusted EPS of \$2.12. For the full year, our total revenues were \$358 billion, an increase of 11% versus the prior year. We delivered adjusted operating income of \$17.5 billion and adjusted EPS of \$8.74. We generated \$13.4 billion of operating cash flow, demonstrating the power of our business model and supporting our strategy.

This morning, we revised our full-year 2024 guidance for adjusted EPS to at least \$8.30 and cash flow from operations to at least \$12 billion. While utilization pressure in Medicare Advantage continues to be attributable to the same categories we have previously highlighted, a part of which was contemplated in our 2024 guidance, we are taking a cautious stance on our outlook for Medicare Advantage utilization until we have further clarity of these industry-wide trends. Tom will provide additional details on the components of our guidance.

While the Medicare Advantage market has been challenged recently, our view of the long-term opportunity offered by this business remains unchanged. As we discussed in December, we are committed to achieving our targeted 4% to 5% margins in Medicare Advantage over time, and we will begin that journey in 2025.

At CVS Health, we have both the scale to transform how health care is delivered, and the ability to personalize care and coverage for each individual we serve. By bringing together the powerful capabilities of our brands including Aetna, CVS Pharmacy, CVS Healthspire and Caremark, we can deliver significant value to the customers and communities we serve and unlock tremendous potential for our shareholders.

When all of our assets work together, we are able to lower the total cost of care, improve health outcomes, deepen patient engagement, and increase loyalty. We are able to unlock up to three to four times more enterprise value when we engage members in more than one CVS Health business. Today, we have more than 55 million CVS Health customers that engage with at least two of our offerings. We see tremendous opportunities to expand engagement with customers across CVS Health through our multi-payer capabilities and vast consumer reach. We're also creating new value in health care with innovative models and offerings that create more transparency and choice for consumers and clients.

In December, we unveiled our new CVS CostVantage model in our Pharmacy & Consumer Wellness business. This model proactively addresses the persistent reimbursement pressures in the retail pharmacy industry. It eliminates cross subsidization, and creates a more durable and transparent pharmacy business that is fairly compensated for value delivered to customers and patients for all prescriptions dispensed. We have made notable progress since we announced the new model in December. We recently delivered initial terms and conditions to several PBMs and are actively engaged in constructive discussions.

CVS CostVantage is a dramatic change to the current reimbursement model, and will provide a clear pathway to greater transparency while passing along our industry-leading cost of goods improvement. We've reached preliminary agreements with multiple cash discount card administrators to begin using CVS CostVantage on April 1. This is a foundational step that sets the stage to create more predictable pricing at the pharmacy counter for consumers.

We also announced our new CVS Caremark TrueCost model. This innovative client option offers pricing that reflects the true net cost of prescription drugs with continued client visibility into administrative fees.

Simplified pricing will help consumers be more confident that their pharmacy benefit provides the best possible price and ensures members have stable access to our national pharmacy network.

Finally, we continue to drive greater adoption of biosimilars and increase the affordability of these critical specialty drugs for our clients and their member.

Beginning on April 1, Caremark will remove Humira from its major commercial template formularies. Through Cordavis, we will offer a cobranded Humira product. Cordavis plays an important role in reducing drug costs while helping to ensure a consistent supply of affordable, high-quality biosimilars for the patients we serve. These steps

are truly innovative and will be pivotal as we look to unlock the tremendous value that new pharmacy models and offerings will deliver for our clients and their members.

We are passionate about expanding access to care, lowering costs, improving health outcomes, and creating more transparency and choice for consumers. Our colleagues are committed to this important purpose and will deliver on these goals.

I'll now turn to the highlights from each of our businesses in the quarter.

In our Health Care Benefits segment, we continue to navigate through elevated utilization trends in our Medicare Advantage business. In the quarter, we grew revenues to nearly \$27 billion, an increase of over 16%, and delivered adjusted operating income of \$676 million. Medical membership ended the year at 25.7 million, an increase of 1.3 million members versus the prior year, reflecting growth across multiple product lines, including individual exchange, Medicare and commercial.

Medicare Advantage is integral to the CVS Health strategy. After a very successful 2024 annual enrollment period, we expect to add at least 800,000 new members in 2024. Our success was driven by targeted investments that were strengthened by CVS Health assets and allowed us to create differentiated value for members. We are improving member experiences by focusing on simplicity, offering unique designs, and maintaining stable networks.

Last week we received the proposed 2025 rate notice. The funding level was broadly consistent with our expectation, which we do not believe is sufficient to cover current medical cost trends. We believe that the changes to Part D as a consequence of the Inflation Reduction Act necessitate additional funding to cover the comprehensive member benefits provided, and the increased risk that plans are assuming as a result of the redesign. We look forward to providing our comments to CMS in the coming weeks.

In our Health Services segment, CVS Healthspire, revenues grew to more than \$49 billion in the quarter, an increase of more than 12%, reflecting strong growth in our Pharmacy Services business as well as the acquisitions of Oak Street and Signify Health. Adjusted operating income grew more than 4% to nearly \$1.9 billion.

In our Caremark business, we recently completed a highly successful welcome season. We onboarded more than 3 million new members and ensured our patients had access to their critical medications and specialty therapies. Our consistent ability to deliver exceptional customer and member experience is what makes Caremark a leader in the marketplace.

We continue to drive success in our Healthcare Delivery business. We have tremendous momentum engaging multi-payer Medicare Advantage members with Oak Street clinics through our extensive CVS Health touch points. Oak Street ended the year with 202,000 at-risk lives, an increase of 27% versus the prior year. Through January, the number of Aetna members enrolled in Oak Street clinics has doubled.

Signify Health continues to demonstrate the value of its in-home capabilities for all of our multi-payer Medicare Advantage partners. Signify completed 649,000 in-home evaluations in the quarter, an increase of 20% versus the same period last year. Among our Aetna customers, we are broadening our addressable market, utilizing Signify's strong capabilities in other products including individual exchange and Medicaid. We will be expanding these capabilities with other clients and will deliver value by engaging consumers in their health across multiple channels.

In our Pharmacy & Consumer Wellness segment, which serves more than 120 million customers, revenues grew to more than \$31 billion, an increase of nearly 9% versus the prior year. We generated \$2 billion of adjusted operating income in the quarter, up nearly 10% versus the prior year. PCW's performance in the fourth quarter was driven by strong operational execution. We continue to play an important role in providing access to critical immunizations in the communities we serve, and delivered on pharmacy performance measures for our health plan partners.

We made progress executing on our store closure initiative, having closed 630 stores to date and are on track to close 900 by the end of the year.

On a comparable basis, total same-store sales were up more than 11% versus the same quarter in the prior year. Same-store prescription volumes in the quarter were up more than 4% versus last year.

2023 highlighted our exceptional execution and the power of our diversified business. Our financial performance and differentiated strategy create strong momentum into 2024. Our integrated health model grows in relevance and importance every day for the consumers, customers, communities, and the shareholders we serve.

I will now turn the call over to Tom to provide more details on our results and our guidance.

Tom?

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

Thank you, Karen, and good morning, everyone. Our fourth quarter results truly highlight our unwavering focus on execution and the power of our diversified businesses. We ended the year with strong results in key metrics such as revenue, adjusted earnings per share, and cash flow from operations. A few total company highlights.

Fourth quarter revenues of nearly \$94 billion increased by nearly 12% over the prior-year quarter, reflecting strong growth across each of our businesses. We delivered adjusted operating income of approximately \$4.2 billion and adjusted EPS of \$2.12, representing growth of approximately 4% versus the prior year. These increases were primarily due to strong results in our Pharmacy & Consumer Wellness and Pharmacy Services businesses, as well as lower corporate expenses, partially offset by continued pressure in Health Care Benefits. Our ability to generate cash remains outstanding with full-year cash flow from operations of \$13.4 billion.

Shifting to details for our Healthcare Benefits segment, we delivered another strong quarter of revenue growth versus the prior year. Fourth quarter revenue of \$26.7 billion increased more than 16% year-over-year, reflecting growth across all product lines, particularly in our individual exchange and Medicare businesses. Membership was 25.7 million, a slight decrease of 29,000 members sequentially, reflecting the impact of Medicaid redeterminations, partially offset by growth in individual exchange.

Adjusted operating income for the fourth quarter was \$676 million. The decline in adjusted operating income versus the prior year was primarily driven by growth in the individual exchange business, including the related impact of seasonality, and increased utilization in Medicare Advantage, partially offset by higher net investment income.

Our medical benefit ratio of 88.5% increased 270 basis points from the prior-year quarter primarily reflecting higher Medicare Advantage utilization and a lower contribution from positive prior-period developments.

Utilization pressure continues to be attributable to the same categories we highlighted in the previous quarter, including outpatient and supplemental benefits such as dental and vision. We also saw an uptick in costs related to seasonal immunizations, including the newly launched RSV vaccine. Other categories remain largely consistent with our previous medical cost trend assumptions.

Days claims payable at the end of the quarter was 45.9, down 4.4 days sequentially, and returning to normalized levels consistent with what we experienced in pre-COVID periods after adjusting for the impact of Medicaid pass-through payments. Overall, we remain confident in the adequacy of our reserves.

Our Health Services segment, which includes our Pharmacy Services and Health Care Delivery businesses, generated revenue of approximately \$49 billion, an increase of more than 12% year-over-year. This increase was driven by pharmacy drug mix, growth in specialty pharmacy, brand inflation and the addition of Signify and Oak Street. These increases were partially offset by the impact of continued client price improvements.

Adjusted operating income of nearly \$1.9 billion grew approximately 4% year-over-year, primarily driven by improved purchasing economics and growth in specialty pharmacy, partially offset by ongoing client price improvements.

Total pharmacy claims processed in the quarter increased slightly versus the prior year. The increase was primarily driven by net new business and increased utilization. The increase was largely offset by the impact of the New York Medicaid carveout. Total pharmacy membership as of January 1, 2024, was approximately 89 million members, down primarily due to the previously announced loss of a large client.

We continue to be encouraged by the performance and growth of our Health Care Delivery assets. Signify generated revenue growth of 39% in the quarter compared to last year. Oak Street ended the quarter with 204 centers, an increase of 35 centers in 2023. We continue to expect to add 50 to 60 centers in 2024.

Oak Street also significantly increased revenue in the quarter, growing 36% compared to the same quarter last year.

Shifting to our Pharmacy & Consumer Wellness segments, we generated revenue of over \$31 billion, up nearly 9% versus the prior year and over 11% on a same-store basis, reflecting the impact of pharmacy drug mix, increased prescription volume, brand inflation and increased contributions from vaccinations. These revenue increases were partially offset by the impact of recent generic introductions, continued reimbursement pressure, and a decrease in store counts.

Adjusted operating income was approximately \$2 billion, an increase of nearly 10% versus the prior year, driven by improved drug purchasing, increased contributions from vaccinations, the increased prescription volume described above, and lower operating expenses. These increases were partially offset by continued pharmacy reimbursement pressure.

Same-store pharmacy sales were up 15.5% versus the prior year, and same-store prescription volumes increased by 4.4%. Same-store sales and front store were down by about 3% versus the same quarter last year.

Shifting to the balance sheet, our liquidity and capital position remain excellent. Our ability to generate cash flow remains a core strength of our organization. Full year 2023 cash flow from operations were \$13.4 billion. We ended the year with approximately \$735 million of cash at the parent and unrestricted subsidiaries. We remain

committed to maintaining our current investment grade ratings while preserving flexibility to deploy capital strategically.

In the fourth quarter, we returned \$779 million to shareholders through our quarterly dividend. We also entered into a [ph] \$3.6 billion (00:19:15) accelerated share repurchase transaction which became effective on January 3, 2024.

Turning now to our full-year outlook for 2024. In recognition of the marketplace uncertainty around utilization trends in Medicare Advantage, we revised our 2024 adjusted EPS guidance to at least \$8.30.

In the Health Care Benefits segment, we now expect our 2024 medical benefit ratio to be approximately 87.7%, an increase of 50 basis points from our previous guidance. As I already noted, we observed elevated medical cost trends in our Medicare Advantage business in the fourth quarter which pressured our full year 2023 medical benefit ratio by approximately 10 basis points relative to our prior guidance. The remaining pressure in the quarter was largely a function of mix and higher revenue offsets than we previously projected.

Based on our review of our recently completed fourth quarter 2023 medical cost trend analysis, we are prudently assuming that the elevated medical cost trends we observed in the fourth quarter will carry forward into 2024. Accordingly, we have increased our full-year 2024 MBR guidance by approximately 40 basis points to account for this pressure.

As discussed throughout 2023, we have included a provision for elevated utilization in our 2024 medical benefit ratio guidance and will continue to hold that provision until we have more clarity on the Medicare Advantage utilization environment.

Our revised outlook also reflects an expectation of at least 800,000 new Medicare Advantage members in 2024. As we have previously discussed, the profile of these new members is attractive with nearly three-quarters of these members switching from other Medicare plans and about one-third of members expected in D-SNP plans.

We continue to expect these new members will be neutral to earnings, but the mix impact from incremental new membership represents approximately 10 basis points of today's 2024 MBR guidance revision. When combined with the additional 40 basis points of medical cost pressure we are projecting, we have increased our 2024 MBR projection by 50 basis points to 87.7%.

We anticipate a number of favorable items will partially offset the impact of the expected elevated utilization levels, including higher investment income and higher than previously projected commercial membership. Adding up all the pieces, we now expect adjusted operating income for the Health Care Benefits segment to be at least \$5.4 billion, a decrease of \$370 million from our prior estimates.

In our Pharmacy & Consumer Wellness segment, we now expect a portion of the outperformance from the end of 2023 to persist into 2024. As a result, we now project adjusted operating income of at least \$5.6 billion, an increase of approximately \$90 million from our prior guidance.

In our Health Services segment, we're updating 2024 adjusted operating income to at least \$7.4 billion, a decrease of approximately \$90 million. While our Health Care Delivery businesses were able to successfully manage through medical cost trend pressures in 2023, we think it is prudent to recognize the potential for emerging risks with our payer partners until we have further clarity on 2024 utilization trends.

Finally, we've made a corresponding adjustment to cash flow from operations which we now project will be at least \$12 billion this year.

As you think about the cadence of earnings in 2024, we expect to generate less than 50% of our adjusted EPS in the first half. More specifically, we expect to generate roughly 20% of full-year adjusted EPS in the first quarter. This pattern will look different than 2023, primarily due to the way Medicare Advantage utilization emerged over the course of 2023 and the timing and impact of prior-period developments.

As a result, Health Care Benefits 2024 MBR will see the largest year-over-year increase in the first quarter and the smallest in the fourth quarter. You can find additional details on the components of our updated 2024 guidance on our Investor Relations webpage.

Beyond 2024, we are committed to returning our Medicare Advantage margins to our target of 4% to 5% while also preserving the projected returns on capital for our 2023 acquisitions. Our stars recovery in 2025 will enhance our earnings trajectory, even as we work to adjust our plans to account for the preliminary 2025 Medicare Advantage rate notice, which does not adequately cover recent medical cost trends.

For 2025, our goal is to deliver low-double-digit adjusted EPS growth off our updated 2024 guidance. We expect to update investors later this year on our progress against this goal.

To conclude, 2023 was a year where CVS Health demonstrated the power of our diversified enterprise. As we begin 2024, we remain focused on operational execution and sustainable growth as we advance our goal of becoming the leading health solutions company for consumers.

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

QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] Our first question today comes from Lisa Gill from JPMorgan. Lisa, please go ahead. Your line is open.

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Q

Hi. Thanks very much. Good morning. Tom, thanks for all of that color. But I just want to go little bit deeper and just really understand, how do I think about what happened in the fourth quarter, how that is influencing how you're thinking about 2024? What happened from your Investor Day in December that's really influencing this? Did you see claims coming in throughout December that's influencing how you're thinking about 2024?

And then you touched a little bit on this around the new members and the fact that they're switchers and the impact there. But just wondering if you can give us any more color on how to think about their risk coding and the level of comfort that you have there just dipping just 10 basis points with adding so much membership. And then just lastly, how do I think about medical cost trend versus supplemental benefits when we think about 2024?

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Sure. Thanks, Lisa. Maybe I'll take the first part of that, and I'll ask Brian to take the back parts. So as you think about what changed from our Investor Day, we actually saw really high levels of paid claims in the back half of December. And we noted that when we appeared at your conference in January. As we dove deeper into what went on in the fourth quarter, maybe let me just walk you through what we've seen in aggregate.

So if you start with the fourth quarter of 2023, and just, let's think about its impact on the full-year performance. So we ended the year at 86.2, which was about 20 basis points higher than our guidance. Roughly half of that pressure is things that we do not believe should carry into 2024. So key drivers of that would be things like Medicaid pass-through payments and also higher SEP membership. As you know, once redeterminations start to end in the first half, we shouldn't see that same sort of pressure in the back half of this year. And we've also repositioned our portfolio across the board in individual.

As you think about the other half, that 10 basis points, that's all related to the trend pressure that we saw in Medicare. So it's a lot of the same categories though that we've been talking about all year and that we've been trying to actively get ahead of in our guidance.

So outpatient trend accelerated slightly in the fourth quarter, so hips and knees. We also continue to see elevated trends in supplemental benefits, but really is more dental and vision than the OTC cards that we talked about earlier this year. And finally, we saw some pressure in the quarter from vaccinations, which is really RSV related.

As we look across the other categories, the cost trends themselves on a dollar basis, they're essentially in line with where it is that we thought that they would be. So how does that translate then into 2024? We've taken that 10 basis points of pressure and we've pulled it through into the 2024 baseline. So accordingly, we've increased our estimate for medical costs by over \$400 million in our forward guidance for 2024.

With the additional mix impacts from the new members, that additional 200,000 plus that we've talked about since Investor Day, we think that that gets you to about a 50-basis-point increase, which is the totality of what we've

done this morning. As I said in the prepared remarks, I'd just remind you, when we first started talking about our guidance for 2024 at the second quarter call, we talked about putting an additional provision into 2024 for enhanced utilization. We've maintained that provision in our guidance. And so we hope that that will be a prudent posture, but we want to see where trends are going to settle.

I'd also just note that as you think about the Medicare business now, that book is now only projected to be marginally profitable in 2024. And that's something that we will actively be looking to address with our 2025 bids.

Think I'll turn it over to Brian.

Brian A. Kane

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

A

Yeah. I would just add on the new members, Lisa, to your question, there's nothing that we've seen in those new members that would give us pause. The risk scores look reasonable. The fact that so many of the members are switchers is a really important component of that. The fact that we have a big portion that are D-SNPs, a third, as Tom mentioned in his remarks, matters because we don't have a stars issue in that book of business.

So overall we feel good about the new membership, and I would just add that that new membership also has a very important tailwind for 2025 as those members get coded next year and as the costs of the distribution wear off for 2025. So we feel very good about the new members that we received. There's nothing that we've seen that gives us pause there, and we think everything is fully reflected in our 2024 guide as Tom went through.

With respect to your question on supplemental benefits, we believe we've fully reflected the cost of those benefits in our 2024 guide. We mentioned on the last quarterly call that we've effectively assumed full utilization of those flex cards that were giving us a lot of challenges this year, and the dental and vision type pressure has also been fully reflected in our guide.

Again, we feel good, as Tom said, that we've fully reflected the 2023 baseline in our 2024 numbers. We put a normalized, very reasonable trend on top of that baseline, and today we put additional dollars on top of that through the increase in the MBR. So all in all we feel good about how we're positioned for 2024.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

Yeah. And, Lisa, I just want to reemphasize the point that Tom made about 2025. And I said this in our prepared remarks, that we are committed for margin recovery in Medicare Advantage for 2025, and we'll account for that in our bids.

Lisa C. Gill

Analyst, JPMorgan Securities LLC

Q

Great. Thank you for the comments.

Operator: The next question comes from Justin Lake from Wolfe Research. Justin, your line is open. Please go ahead.

Justin Lake

Analyst, Wolfe Research LLC

Q

Thanks. Good morning. I wanted to ask about the 2025 bidding strategy. And specifically, I know you're going to get some tailwind and margin improvement from stars in 2025. I wanted to talk beyond that. I found your comments helpful on the rates, and I know that could be a pressure. And that's going to cause benefit reductions. But beyond that, do you expect to cut benefits beyond whatever the rates would suggest to start recapturing margin beyond stars for the higher cost trend? How should we think about that positioning for 2025? And how quickly do think you get back to that 4% to 5% margin? Thanks.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

Hey, Justin. It's Karen, and I'll hand this over to Brian in a second. But I just want to comment on the rate notice because that's critical to how we think about 2025 bids. There's kind of three things I would say here. One is we believe it's in line with our expectations relative to being flat. However, we do not believe it covers overall cost trends that have been emerging in Medicare Advantage. We also know that there's complexity around the risk model, and so we'll be contemplating that as we think about our bids.

And then finally, there's some uncertainty around how the Inflation Reduction Act impacts Part D, and that we'll be taking that under consideration when we do our bids as well and providing comments to CMS relative to these points. So all of those will factor in to our bid process, but we will be driving for margin recovery. And let me have Brian specifically answer your detail questions.

Brian A. Kane

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

A

Sure. Thanks, Karen. And I'll just reiterate again that we are committed to the 4% to 5% margin. It's top-of-mind and extremely important that we get there. As we've said multiple times, it will be a multi-year journey to get there, but we intend to take significant ground against that target in 2025 while also being very disciplined in reflecting the trends that we see in our business to make sure that that's fully reflected in the pricing.

Karen mentioned some of the headwinds with respect to the rate notice and that we don't believe it fully reflects medical trend. There are some issues around Part D that we need to work through as the benefit has been meaningfully enhanced as part of the IRA. And also we as an industry are taking on meaningfully more risk in the catastrophic layer that will have to be reflected in our bids, and that's something we intend to do. We are also limited, as you know, by TBC, or total beneficiary change, limitations that we are working through that could to some extent constrain what we're able to do.

That being said, we do intend to take additional margin actions. Our goal is to do so in excess of our stars tailwind that we have. I would also note, as I mentioned in the prior question that Lisa asked, it's really important to think about this 800,000 members that we're getting as a meaningful tailwind to 2025, again because these members haven't been fully documented from a coding perspective and because the distribution costs are very expensive throughout the year. That will wear off in 2025, and so you get a nice tailwind there.

The last point I'd make which I think is important is that although the IRA did enhance the benefits as we said on Part D, the result of that will likely be, notwithstanding some of the risk model changes that were made for PDP, will likely result in meaningful premium increases on the PDP side which we believe will actually help the relative attractiveness of MA. And I think that's an important component as we think about the attractiveness of MA for 2025.

And the last point I'd make, which I think is important as an industry, not only does MA offer superior benefits, and we believe that even with some of the changes that we intend on making it'll still be a compelling value proposition

for our customers, but the thing that doesn't get talked about enough is the significant benefits around care coordination, around navigating the health care system that our members get as a result of choosing an MA plan that is far superior to a traditional Medicare fee-for-service plan. And that's something that will be top-of-mind for us. And our intention is to continue to enhance that experience, especially with our new members, to make sure that we retain them for 2025.

Operator: The next question comes from Kevin Caliendo from UBS. Kevin, your line is open. Please go ahead.

Kevin Caliendo

Analyst, UBS Securities LLC

Q

Thanks. Thanks for taking my question. I want to go maybe a little bit further on Justin's question. And when you think about getting the 4% to 5% over time, I guess what we're all trying to understand or worried about or maybe it's the strategy. It's like your positioning, can you still take share and enhance margin knowing what you know? Maybe talk a little bit about how CVS is positioned in their ability to bid versus others in the marketplace. What are your advantages and disadvantages? And can you – with stars coming back or not. But can you get to your margin targets and still grow in line or better than the expected market growth?

Brian A. Kane

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

A

Well, look. I appreciate the question. There's still some questions out there. We got to see where the final rate notice obviously shakes out in terms of overall where margins can go and of course get a real handle around where we think trend will be for 2025, be very disciplined about that, and so that'll be an important calculus as we think about margin recovery.

As we think about relative share, look. We believe that we have a compelling value proposition as an enterprise with all the various assets we can bring to bear for our Medicare members. We do think that our stars coming back does, on the margin, provide an advantage there. As I will reiterate again, the significant membership growth that we got in 2024 also gives us some tailwinds going into 2025.

But I will tell you we are first and foremost focused on recovering margin, and market share gains is a secondary consideration. Obviously we want to grow. As I said in the prior question, we believe this is a compelling space. We believe it's compelling for members, and we believe we have the assets to be able to manage those members and provide superior customer experience relative to the competition. As a consequence, I think we're very well positioned to grow our business and over time take share.

Operator: The next question comes from Nathan Rich with Goldman Sachs. Nathan, please go ahead. Your line is open.

Nathan Rich

Analyst, Goldman Sachs & Co. LLC

Q

Great. Good morning, and thanks for the questions. It's obviously been challenging this year for many companies to kind of get their hands around utilization. So I don't know if you have any kind of early comments on how January played out maybe relative to the fourth quarter on both the outpatient trend as well as supplemental benefits.

And then as it relates to the 2024 MBR now I think being up 150 basis points, I guess at a high level, would you be able to break that increase down between utilization pressure, the impact that new members will have, the

stars headwind that you face? And is there pressure also in there from the risk model, or is that something that you price for, just as we think about the different components that contribute to the 2024 MBR? Thank you.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Nate, why don't I take the second part of your question first and then I'll turn it back over to Brian. So as you look at the year-over-year MBR increase, almost the entirety of it is related to the Medicare Advantage business. So there's some smaller items. So we have an improvement in our individual exchange business, and then there's some other offsets there. But we also, as we think about our guidance, we never project prior-year reserve development. And so those two for the most part net.

And so, what you are left with is the vast majority of the increase is related to Medicare. And so about 65 basis points of that specifically relates to the \$800 million stars headwinds that we have. And then the remainder is a combination of provisions for the new member mix, because we're assuming the higher MBR there, and that that will be plus or minus breakeven. And then the rest of it is really a provision for Medicare utilization pressure.

Brian A. Kane

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

A

And with respect to January trends, it's really way too early to comment on that. There's nothing that we've seen in our January data that gives us pause relative to the guidance that we've given today. Obviously, we're going to monitor it very closely, as you can imagine. And as we get more information we will absolutely share that with you.

I would comment just on the risk model, just make a quick comment about the V28 provisions. And we talked about this at our Investor Day. Not every player is impacted the same way by this. And as we've said, we have a relatively low portion of duals and D-SNPs. It's obviously something that we're growing significantly this year. But we're way under-indexed to D-SNP relative to some of our competitors. And I think that's an important element because that's a population that's been impacted more by these risk model changes.

We also, and we think this is ultimately an opportunity, but we also are under-penetrated when it comes to our full risk VBC relationships. And those types of relationships also result in I would say bigger impact on V28 relative to a non-VBC type relationship. This is something, again, we want to expand over time, and it's a critical strategic priority for us. But with respect to the risk model change, we're actually benefited by the fact that we have a much lower penetration than some of our peers.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Nate, I might just say one of the things that we spent a lot of time looking at specifically was inpatient. And there are some puts and takes there. But on the whole, that category remains consistent with our expectations. Now we did make a provision in both our bids, and therefore, which is incorporated in our guidance for the changes that would happen in January from the two-midnight rule. That's fully encapsulated inside the guide, and it's something that we're obviously watching very closely because of to make sure that our estimate is consistent with what we're going to see come through the system.

Operator: The next question comes from Ann Hynes from Mizuho. Ann, your line is open. Please go ahead.

Ann Hynes

Analyst, Mizuho Securities USA LLC

Q

Great. Thanks. Maybe I'll shift away from MLR and focus on retail and just the new pricing model. I know you discussed it in your comments, but can you just give us any more details on the initial feedback you're receiving from payers? Have your discussions changed your view on the ability to change the model or the timing? And just to clarify, this a mandatory program, so payers basically have to switch with you. And I guess what's the risk of payer relationships if they don't want to? Thanks.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

Good morning, Ann. Yeah. I would say that the comments and the feedback have generally been positive with the discussions initially. Obviously there's a lot of details to go through and to work through. But we're really pleased with the initial reaction. And I'll ask Prem to give you a little bit more detail here.

Prem S. Shah

Executive Vice President, Chief Pharmacy Officer & President-Pharmacy and Consumer Wellness, CVS Health Corp.

A

Yeah. Thanks for the question, Ann. And what I'd say is we launched the model at Analyst Day and we're really excited about the progress we've made. We've been able to, over the course of the last week, deliver the initial terms and conditions to several of the pharmacy benefit managers and are very engaged in constructive discussions with all of them. What really excites me is we're leading the way in providing greater transparency in drug pricing and passing through our leading cost of goods through to payers in our new model. So this is not about effectively raising price. This is about continuing to pass through our size and scale and the acquisition costs that we receive back to payers and provide a transparent model that can benefit consumers and payers as we go forward.

Remember, one of the biggest challenges as you think about the health care ecosystem and the problems we face is the rising cost of brand drugs. And if you think about what the biggest pain point for our payers is, it's the fact that these brand drugs and specialty drugs now constitute the majority of the trend that kind of gets passed through to the payers and plan sponsors. It's not the pharmacy reimbursement that's driving that.

So, and just some quick data points on that. If you think about the impact of GLP-1s in 2022 to the system, it was about \$14 billion. Right? And that continues to grow. So from my perspective, we continue to have good discussions with payers. We're driving forward on eliminating some of the key problems in the system such as cross-subsidization and creating an easier path and a much more transparent path to allow payers and consumers to receive their pharmaceuticals in the US. And more to come as we make progress over the course of the next couple of quarters.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

And Ann, I would just remind everyone that the industry has continually talked about the importance of driving cost transparency and affordability and simplicity. And with this model and our TrueCost model, we are really leading at the forefront to support those items. And I think as Prem has been out in the market, there's a lot of support for this.

Operator: The next question comes from Josh Raskin from Nephron Research. Josh, your line is open. Please go ahead.

Joshua Raskin

Analyst, Nephron Research LLC

Q

Thanks. Good morning. Here with Eric as well. I'm going to hopefully close the loop on the MA side. So can you speak to just your philosophy overall on MA bids? And do you consider the benefit of the enterprise from growth, or does the HCB segment have to stand on its own when you talk about that 4% to 5% margin? And can you speak to the impact of growing your Healthspire assets and how that impacts your MA bid strategy? I'm specifically thinking about growth in – Oak Street probably creates a short-term headwind but long-term enterprise value. Thanks.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

So Josh, the way we think about it is that 4% to 5% margin needs to be at HCB, and then we get the benefit of our growth from all the other assets that we can bring to bear for the company. So that's our philosophical approach to MA bids. And then relative to how the Healthspire assets can support MA, I'll ask Mike to give you some comments on that.

Michael T. Pykosz

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

A

Yeah. So one of the key parts of the partnership we have with Aetna but with all of our payers is we have additional levers we can pull at HCB to positively impact patient care quality, positively impact outcomes and then lower medical costs. Right? And that can be on Signify delivering in-home assessments to identify patient disease burden so we can treat it appropriately, and that can be on Oak Street Health having more leverage as a PCP to further lower MLR.

So our job is for all of our payer partners to provide substantially better care. And so obviously when our payer partners are growing and taking share, right, a lot of that growth trickles down to us and becomes a tailwind for us.

But one of the advantages I think we have as a health care delivery organization is the more levers to pull. And one quick example for the group is we bought a company at Oak Street called RubiconMD a couple years ago, and we leveraged e-consults to help provide better access to specialty care and lower costs. And we fully implemented the e-consult program in 2023 at Oak Street. And through that implementation we were able to lower trend 1% across our entire book. And that is one reason we were able to hit our expectations at Oak Street on MLR and profitability despite the increase in a lot of the utilization categories that Tom discussed that we saw as well.

And so I think a lot of our strategy is dependent upon being able to drive higher quality and lower cost through those levers.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Hey, Josh, maybe let me wrap this up. As we think about this from the enterprise perspective, all of our businesses need to earn their cost of capital, and they need to earn their return on that capital. And so as you think about Medicare, it's a mid-\$60 billion revenue business that we targeted a 4% to 5% margin on for 2023. We clearly didn't achieve that, and as we look at our projections for 2024, as I noted, it's only marginally profitable.

As you think about that business, we're putting a high-teens percentage of dollars in risk-based capital behind every dollar of premium. And so it's imperative that that business earn its margin to earn its cost of capital and returns on capital. That's just how we think about it from an enterprise perspective.

And we've spent a lot of money over the course of 2023 to develop capabilities which we believe will be additive, and we have been very specific with investors about what we expect those returns on capital to be over time. And we're committed to achieving them, which means we're committed to achieving target margins in each of those businesses that we acquired.

Operator: The next question comes from Elizabeth Anderson from Evercore ISI. Elizabeth, please go ahead. Your line is open.

Elizabeth Anderson

Analyst, Evercore ISI

Q

Hi, guys. Thanks so much for the question. I wanted to maybe dig into the pharmacy services profit guidance for 2024 in a little bit more detail. Can you just go through what are the key tenets of your assumptions that changed there versus the guidance that you gave at the Investor Day in December? Thank you.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Elizabeth, did you mean the Health Services segment, I presume? So really what's changed there, I'd say...

Elizabeth Anderson

Analyst, Evercore ISI

Q

Yes. [indiscernible] (00:49:24) if that's not what I said, that's what I mean. Sorry. Yes.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Yeah. As you think about that, I noted this a little bit in the prepared remarks. As we think about what the external utilization environment looks like, we felt it was prudent to recognize that, as a multi-payer business, that there could be impacts outside our ecosystem that might pull through into that business. As Mike said, we spent a lot of time – he spends a lot of time thinking about what of the reserving practices are and what their medical cost trends are inside the Oak Street and also our ACO businesses. And we try to supplement that as we can with other insights about what it is that we're seeing across our book. But as we thought about what we're hearing in the marketplace, what we saw in our own book in the fourth quarter, we thought it was prudent to pull through some of that potential utilization pressure into our outlook, primarily on our health care delivery assets.

Operator: The next question comes from Stephen Baxter from Wells Fargo. Stephen, your line is open. Please go ahead.

Stephen Baxter

Analyst, Wells Fargo Securities LLC

A

Yeah. Hey. Thank you. I just wanted to follow up on that question precisely. When we look at the guidance reduction for the services business, it does look like it's less than I think the implied 100 basis points guide up on MA MLR that you're talking about for your own book of business. So just hoping you could expand a little more

specifically what's included in the increase loss ratios for the Oak Street business. And then are you potentially also carrying some of the 2023 outperformance into your 2024 outlook, as an offset? Thanks.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Yeah, Steve, I think that it's important as you think about the guide that you realize two things. Number one, health care delivery is part of a much larger segment. Right? And so we believe that we've made appropriate provisions in the segmental guidance there for what the potential pressures might look like.

The second thing I would just remind you is that we had a very successful 2023 in those businesses. And so those businesses were able to successfully manage through the pressures that we and most of our peers saw in Medicare Advantage and still achieve the targets that we were looking for out of those businesses in 2023.

So we were very pleased with that performance, and – but we took a prudent outlook and cautious, hopefully, outlook as we thought about where 2024 might land based on the external environment.

Operator: The next question comes from Allen Lutz from Bank of America. Allen, your line is open. Please go ahead.

Allen Lutz

Analyst, BofA Securities, Inc.

Q

Good morning and thanks for taking the questions. One for Tom or Prem. On the retail pharmacy side pharmacy script volume was really strong. So how should we think about growth there through the end of the year, and ex-COVID? And then are you seeing any noticeable benefits from the bankruptcy of one of your peers? Thanks.

Prem S. Shah

Executive Vice President, Chief Pharmacy Officer & President-Pharmacy and Consumer Wellness, CVS Health Corp.

A

Thanks for the question. I'd say a few things. One as we've entered this year and throughout Q4 we've had extremely strong service in our pharmacy businesses. And as we mentioned before, pharmacy relationships are sticky and they really are driven by the great experiences we can provide at the counter. So we feel really good going through this year as it relates to our service. And there's been a few market disruptions, as you mentioned, in the marketplace. From our perspective, we continue to make sure that we invest in our stores in the right way, prioritizing experiences, as I said. And we'll look at certain markets for opportunistic file-buys if they make sense, as we've historically done over time. But we feel really good about our script performance coming into the year. And it's in line with our expectations as we look at this.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Nate (sic) [Allen], as you think about this business, one of the things that we've said that we've tried to do consistently is to grow share to help to offset reimbursement pressures. And as you look at the fourth quarter, we certainly had – I'm sorry that was Allen. We certainly had – we had same-store growth. You got to really think about what the impact of store closures might be as you think about our overall market share. But we had same-store growth in prescriptions that was in the high 4% range versus a market that grew in kind of a mid-2%^s. And so we feel like the team's really continued to execute really well in helping to drive to the results that ultimately get us onto the long-term trajectory that we outlined at Investor Day.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

And, Allen, I'd also note and we said this in the prepared remarks, that we've been making good progress on our store closures and we've been retaining scripts and retaining colleagues, which was critical to the success of those store closures as well.

Operator: The next question comes from Charles Rhyee from TD Cowen. Charles, your line is open. Please go ahead.

Charles Rhyee

Analyst, Cowen & Co. LLC

Q

Oh, yeah. Thanks for taking the question. I wanted to go back to CostVantage a little bit here. And when we think about how you're setting up those acquisition costs, can you talk about the reaction from payers a little bit more in regards to how they're seeing – what cost that you're passing through? I think one of the issues or concerns that have been raised is the potential for sort of perverse incentives. Right? A pharmacy could prefer a higher acquisition cost drug because the markup is higher.

And one of the solutions that we've heard mentioned was potential of setting up maybe global caps on reimbursement for classes of drugs. Just making up numbers here. No more than, I'd say, AWP minus 90 for generics or something like that. Is that something that you are discussing with payers? And what are the measures that you are contemplating to ensure incentives are aligned? Because I'd imagine payers are really interested that.

Prem S. Shah

Executive Vice President, Chief Pharmacy Officer & President-Pharmacy and Consumer Wellness, CVS Health Corp.

A

Yeah. I think that – first and foremost, I think there's a few parts to your question. Last week, we delivered our terms and conditions, so the payers now have the ability to understand how our model will work. As a reminder, our model is based on a simple transparent formula that's built upon the underlying acquisition cost of the drugs defined by, plus, a defined markup and dispensing fee. To your point on there's many different ways in pharmacy pricing, my perspective on this is the way we've approached this is in a very transparent way, so that payers can receive the benefits of someone like CVS retail pharmacy where we have the operating scale and the operating discipline to drive further acquisition cost down on generics through our procurement and other strategies. And so we will always be held accountable for reducing acquisition costs, leveraging our scale and size to do that, and also performing and delivering services at the lowest price possible.

At the same time, payers also need a viable pharmacy marketplace across the community that can provide what I would say is consistent care across all the communities that we serve, so it's critical to meet both of those. And, look, it's February 7, so we're still early in this journey. But we're excited about the progress we've made since Analyst Day, and we're going to continue these payer negotiations and payer discussions over the course of the coming weeks and months, and we'll provide an update as we go forward. And all the things that you're describing are things that we're contemplating and discussing with payers in a very transparent way to eliminate some of the challenges that this industry has had over the course of the last few decades.

Operator: The next question comes from John Branson (sic) [Ransom] from Raymond James. John, your line is open. Please go ahead.

John W. Ransom

Analyst, Raymond James & Associates, Inc.

Q

Hey. Good morning. I got a new name. John Bransom. The question I have is just RSV. It's a good guy to your retail franchise. It's a bad guy to HCB. How do we think about the net benefit or net drag to the enterprise for fourth quarter? And what's embedded in your 2024 outlook just for RSV? Thanks.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Hey, John. I don't know that we're going to give a specific on that as you think about RSV. I would say net the cost of the relative market share differences between our pharmacy business and the Aetna business, that tends to be a net tailwind for the enterprise. We did see pressure inside the fourth quarter in particular, in our Medicare business, but also a little bit in the commercial business inside Aetna as you think about those vaccinations.

Correspondingly, we saw more of a benefit in the Pharmacy & Consumer Wellness segment. As we think about 2024, given the newness of some of these vaccines, what we've tried to do is take a little bit more cautious outlook as we thought about what the pull-through might be for that outperformance in the fourth quarter, and that's why the beat doesn't match the raise as you think about 2024. We'd like to see a little bit more history here before we lean in on that projection.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

And, John, strategically I wouldn't just think about one type of RSV as a vaccine. I want you to think about an immunization franchise that the retail business has really developed, and which is really creating strong value for that business.

Operator: Final question today is from Erin Wright from Morgan Stanley. Erin, please go ahead. Your line is open.

Erin Wilson Wright

Analyst, Morgan Stanley & Co. LLC

Q

Great. Thanks. On Cordavis, I'm just curious, how meaningful is the contribution to segment profit or how meaningful is that embedded in your guidance? And how is that just generally playing out relative to your expectations? And then just a quick one on just PBM and transparency, just your latest thoughts on regulatory changes potentially across the PBM, what we could potentially see this year in terms of what gets passed and ability to manage around that. Thanks.

Thomas F. Cowhey

Chief Financial Officer, CVS Health Corp.

A

Thanks, Erin. Maybe I'll start with Cordavis. I'd say we've been very pleased with the progress to date, and we do have a projection for a positive contribution from that business inside the Health Services segment, and we'll continue to give more details on that as we get through the year, but we haven't disclosed that specific contribution at this point. And maybe I'll turn it over to Karen talk a little bit more about PBM transparency.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

A

Yeah, relative to what's going on in Washington, obviously this is – continued discussions are going on there. I do think that they're talking about transparency. If anything does get passed I think it will be around transparency. But I would tell you that, given some of the actions that we have taken with both TrueCost and CostVantage, that is resonating with the legislators and is helpful in driving overall cost transparency. And I can't predict what's going on in DC, but I know that we're taking action to improve overall outcomes.

Operator: This concludes today's Q&A session.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

I want to thank you for all joining our call.

Operator: This concludes today's Q&A session I'll turn it back to Karen for any concluding remarks.

Karen S. Lynch

President & Chief Executive Officer, CVS Health Corp.

Yes. Thank you for all joining the call today, and I want to thank our colleagues for their continued commitment to delivering on our performance. Thank you.

Operator: This concludes today's call. Thank you very much for your attendance. You may now disconnect your lines.

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