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Q2: 2024-08-07 Earnings Summary

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EPS of $1.83 beats by $0.10 | Revenue of $91.23B (2.60% Y/Y) misses by $197.42M

CVS Health Corporation (NYSE:CVS) Q2 2024 Earnings Conference Call August 7, 2024 8:00 AM ET

Company Participants

Karen Lynch - President, Chief Executive Officer
Tom Cowhey - Executive Vice President, Chief Financial Officer
Prem Shah - Executive Vice President, Chief Pharmacy Officer
David Joyner - Executive Vice President, CVS Health
Larry McGrath - Senior Vice President, Investor Relations

Conference Call Participants

Lisa Gill - JP Morgan
Justin Lake - Wolfe Research
Stephen Baxter - Wells Fargo
Ann Hynes - Mizuho
Eric Percher - Nephron Research
Michael Cherny - Leerink Partners
Elizabeth Anderson - Evercore ISI
Kevin Caliendo - UBS
Lance Wilkes - Bernstein
Charles Rhyee - TD Cowen
Brian Tanquilut - Jefferies

Operator

Good morning or good afternoon all and welcome to the CVS Health Q2 2024 earnings conference call. My name is Adam and I'll be your Operator today.

If you'd like to ask a question at the Q&A portion of today's call, you may do so by pressing star followed by one on your telephone keypad.

I will now hand the floor to Larry McGrath to begin. Larry, please go ahead when you're ready.

Larry McGrath

Good morning and welcome to the CVS Health second 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 statements 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 condition, 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 Lynch

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

Today we reported adjusted earnings per share of $1.83 and adjusted operating income of $3.7 billion for the quarter. Our total revenues were more than $91 billion and we generated $8 billion of operating cash flow in the first half of the year. We are also updating our full year 2024 adjusted EPS guidance to a range of $6.40 to $6.55, based on the continued pressure in our healthcare benefits business offset by strong performance in health services and the pharmacy and consumer wellness business.

The majority of our businesses are performing well and we continue to drive the integrated value of our company by executing on our strategy to connect people to the care and the coverage they need. However, we are disappointed by the current performance and outlook for the healthcare benefits segment, and I have decided to make leadership changes.

Effective immediately, Brian Kane is leaving the company. In the interim, I will assume direct leadership of the healthcare benefits segment. As you know, managed care has been an integral part of both my and Tom Cowhey's professional careers and we will be overseeing the day to day management of this business. In addition, Katerina Guerraz, our Chief Strategy Officer will become the Chief Operating Officer of the healthcare benefits segment. Katerina is a 20-year Aetna veteran with extensive commercial and Medicare experience and has a track record of operational excellence. We are committed to returning healthcare benefits to its rightful place and will drive execution and address the challenges facing this business.

Looking across the enterprise today, CVS Health serves more than 186 million people, and we are making continued progress in proving that our integrated model creates value. When individuals engage with two or more offerings, we can deliver better health experiences and outcomes. Over the first half of the year, we expanded the number of consumers accessing two or more CVS Health offerings to 57.7 million, an increase of nearly 2.5 million consumers. We grew the number of Aetna medical members utilizing CVS pharmacies to 9 million, an increase of 8% from the prior year. We also now have 13.8 million Aetna medical members who are covered by Caremark, an increase of 13% compared to last year. We extended our digital reach with nearly 60 million unique digital customers utilizing our platform to schedule health services appointments, fill prescriptions, and purchase wellness products, all contributing to the growth in our business.

We are committed to transforming the industry with innovative pharmacy models that create greater transparency, reflect the true cost of drugs, and align incentives across stakeholders. We are driving significant progress on the adoption of CVS CostVantage and CVS Caremark TrueCost. To date, we've signed CVS CostVantage agreements with eight pharmacy benefit managers, including CVS Caremark, who combined make up more than 50% of our commercial scripts. Discussions with our large CVM partners are active and constructive as we move forward with full implementation for our commercial contracts on January 1, 2025.

Our TrueCost offering is resonating with commercial clients as they strive to ensure pricing simplicity and transparency for their members. We firmly believe that TrueCost will reshape the future of pricing for every drug, every condition, and every member. Additionally, we implemented this model for CVS Health's more than 300,000 colleagues.

Biosimilars create a meaningful opportunity to deliver additional pharmacy savings to our clients. Through Cordavis, we introduce our biosimilar products at a price more than 80% lower than a reference brand, and we are the only company to move biosimilar share. We have processed approximately 100,000 Cordavis biosimilar prescriptions since we launched our formulary change on April 1, which has contributed to nearly $400 million in net savings for our clients and their members. Cordavis and its success in the biosimilar market was possible because of the combined assets of CVS Health. We will continue to expand our offerings and drive greater access and savings for our customers.

Before I share updates on performance in each of our segments, I want to provide an update on the enterprise productivity initiatives we discussed on our last call. We identified a multi-year opportunity to deliver $2 billion in savings. These savings will be driven by further streamlining and optimizing our operations and processes, continuing to rationalize our business portfolio, and accelerating the use of artificial intelligence and automation across the enterprise as we consolidate and integrate platforms. We will be thoughtful and deliberate as we execute these actions to ensure we continue to meet consumer needs. These savings will create both capacity to invest in our businesses and opportunities for outperformance.

Now let’s look at our businesses in detail.

In healthcare benefits, revenues for the quarter grew to over $32 billion and we delivered nearly $1 billion in adjusted operating income. Medical membership was nearly 27 million, primarily reflecting growth in our Medicare and individual exchange businesses. Our medical benefit ratio for the quarter was 89.6%. Utilization in our Medicare business remained at elevated levels but was largely in line with expectations. Following the close of the second quarter, we saw indications of potential trend acceleration which we have contemplated in our revised guidance range.

Similar to others in the industry, we saw an increase in the dislocation between Medicaid acuity levels and rates. We will continue working closely with our state partners to advocate for rates that more closely align with changes in acuity. Within the quarter, our MBR also reflected the impact of the final 2023 risk adjustment for our individual exchange business. Tom will provide additional details on utilization and the risk adjustment update.

In June, we submitted our bids for the 2025 Medicare Advantage plan. Our bids went through a rigorous internal review and we are confident in our pricing for 2025, which reflects prudent assumptions for utilization trends. The actions we took are expected to drive 100 to 200 basis points of margin recovery in 2025 off of our current baseline and start the multi-year pathway to achieving target margins of 4% to 5%.

As we have previously discussed, we expect to see a decline in Medicare membership in 2025 driven by our margin recovery efforts. In our commercial business, we expect membership growth in 2025 driven by new business wins and strong retention, both of which are running ahead of where we were at this time last year. Our retention rate is in the high 90s with our national accounts business.

In our pharmacy and consumer wellness business, we effectively navigated a changing consumer environment and delivered another strong quarter that exceeded our expectations. We grew revenues for the segment to approximately $30 billion, up nearly 4% versus the prior year, and generated $1.2 billion of adjusted operating income in the quarter. Our growing pharmacy share, now at a record high of approximately 27.2%, was a meaningful contributor to these results.

We continue playing a key role in delivering important community health services, as demonstrated by the approximately 2 million immunizations we administered in the quarter. We are on track to achieve our three-year goal of closing 900 stores by the end of this year, with 851 stores closed to date. We continue to exceed our goals for both colleague and script retention.

As we look at the standalone stores we have remaining across our national footprint, substantially all are profitable. This measure highlights our leadership in this business and our ability to operate nationally while delivering unmatched levels of consumer service. Our position will only improve as we continue to optimize our footprint and implement innovations like CVS CostVantage.

In our health services segment, we generated revenues of more than $42 billion and delivered $1.9 billion in adjusted operating income. Our pharmacy services business, the largest component of the health services segment, delivered strong results driven by the execution on core principles of this business, lowering drug costs and creating savings for our clients. We have retained approximately 99% of employer clients in the 2025 selling season.

I want to take a moment to address the interim 6(b) study released by the FTC. We fundamentally disagree with the FTC's position. When you look at the data, there is clear evidence that PVMs play a crucial role in reducing drug costs. We have a decades-long track record of protecting American businesses, unions and patients from rising prices on prescription drugs. We use competition among manufacturers to help keep drug costs affordable for our members.

The FTC's report focuses on issues of the past. We are leading the industry as we innovate our business model with our TrueCost offering. We believe our model helps ensure greater transparency and pricing and helps consumers to be confident in their pharmacy benefit that is providing the best possible price. Additionally, our programs help patients affordably access critical drugs like insulin. Our members on average pay less than $25 per insulin. Through our reduced Rx program, we provide access to $25 insulin to every customer, whether insured, under-insured or uninsured. We are committed to delivering value every day to our clients and our members.

In our healthcare delivery business, we are driving meaningful progress connecting patients to health services across all of our channels: primary and acute care, health services in the home, and clinical programs. Signify exceeded expectations, delivering another quarter of record volume. We also continue to grow our patient base among Medicare Advantage members with our primary care clinics. Oak Street at-risk patients grew to 235,000, up nearly 30% over the same quarter last year.

We are accelerating opportunities that drive integrated value by connecting Signify and Oak Street to CVS Health assets, such as Aetna, MinuteClinic, and CVS Pharmacy. Since we closed our healthcare delivery acquisition, Signify now serves nearly twice as many Aetna members and to date, the number of Aetna members at Oak Street clinics has more than tripled. We expect this number to further expand as we introduce co-branded Aetna and Oak Street plans in the 2025 annual enrolment period.

We continue to use the powerful relationship we have with patients at the pharmacy counter. This quarter, we saw a seven-times increase in the number of pharmacy scheduled IEGs compared to last quarter. We have many points of differentiation that position CVS Health to win. Our biggest differentiator is how we are bringing our assets together to deliver integrated solutions for our customers.

We are working effectively to address the challenges we face in 2024. The steps we are taking include our disciplined approach to Medicare Advantage pricing, progress on our innovative pharmacy model and our biosimilar strategy, early wins in both CareMark and Aetna selling season, and accelerating the integration of healthcare delivery assets. These actions combined with our multi-year productivity initiatives and improved operational performance in our healthcare benefits segment give us the confidence that we are building positive momentum as we look to 2025 and beyond.

I will now pass it over to Tom for a more detailed view of our second quarter results. Tom?

Tom Cowhey

Thank you Karen, and thanks to everyone for joining us this morning. I'll start with a few highlights on total company performance.

Second quarter revenues were approximately $91.2 billion, an increase of approximately 2.6% over the prior year quarter, reflecting growth in our healthcare benefits and pharmacy and consumer wellness segments. We delivered adjusted operating income of over $3.7 billion and adjusted EPS of $1.83. We also generated year-to-date cash flow from operations of approximately $8 billion, a lower result as compared to the same period last year, primarily due to timing of Medicare payments and the impact of Medicare utilization.

Let's look at some of the performance of our segments. In our healthcare benefits segment, we delivered strong revenue growth versus the prior year. Second quarter revenues of approximately $32.5 billion increased by over 21% year-over-year, reflecting growth across all product lines. Medical membership grew to nearly 27 million members, an increase of 200,000 members sequentially, reflecting growth in Medicare and Medicaid products including the Oklahoma Medicaid contract, which went live on April 1.

Adjusted operating income for the quarter was approximately $938 million, down year-over-year due to a higher medical benefit ratio, partially offset by an increase in net investment income. Our medical benefit ratio of 89.6% increased 340 basis points from the prior year quarter primarily reflecting higher Medicare Advantage utilization, the premium impact of lower Star ratings for the payment year 2024, the impact of higher acuity in Medicaid, and the change in estimate for individual exchange risk adjustment accrual for the 2023 plan year. These increases were partially offset by the favorable year-over-year impact of prior period development.

In Medicare Advantage, strong prior period reserve development improved our first quarter medical cost trend estimates, but we continued to see elevated trends in the second quarter largely in the same categories we previously discussed, including in-patient, supplemental benefits such as dental, and also in pharmacy. Following the close of the quarter, we have seen some evidence of an acceleration of trends in these same categories, which informed our view of risks for the remainder of 2024.

We also experienced medical cost pressures in our Medicaid business. This pressure is largely driven by higher acuity resulting from member redeterminations. We believe this dislocation will self-correct over time as we continue to work closely with our state partners to ensure the underlying trends are reflected in our rates, but we have not assumed material improvement in our 2024 outlook.

During the quarter, we received final 2023 risk adjustment data for our individual exchange business. As a result, we increased our risk adjustment accrual for the 2023 plan year by approximately $225 million. We were disappointed to see such a large change in the final update. We believe this change was in part driven by the significant growth and disruption in the market, particularly late in 2023. For 2024, our population contains a significantly higher proportion of renewing members, and we continue to enhance our revenue integrity efforts to ensure we are appropriately capturing their acuity.

As a result of this update, we now expect margins for our individual exchange business to be below breakeven this year; however, we are confident that our 2025 submitted rate filings, which we further enhanced following the 2023 risk adjustment update, will place us back on our multi-year margin trajectory.

Medical cost trends in our commercial business remain elevated but are broadly in line with our expectations and pricing.

Days claims payable at the end of the quarter were 43.1 days, down 1.4 days sequentially and 3.8 days from the prior year quarter. The decrease versus the prior quarter was primarily driven by elevated reserves held in the first quarter of 2024, including the impact of the Change Healthcare cyber attack. The year-over-year change in DCP was primarily driven by growth in our Medicare business and the impact of increased pharmacy trends. We remain confident in the adequacy of our reserves.

Our health services segment generated revenue of approximately $42.2 billion, a decrease of approximately 9% year-over-year primarily driven by the previously announced loss of a large client and continued pharmacy client price improvement. These decreases were partially offset by pharmacy drug mix, increased contributions from our healthcare delivery assets, and growth in specialty pharmacy.

Adjusted operating income of approximately $1.9 billion increased over 1% from the prior year quarter, reflecting improved purchasing economics partially offset by continued pharmacy client price improvements and the previously announced loss of a large client.

Total pharmacy claims processed in the quarter were approximately $471 million, and total membership as of the end of the quarter was approximately 90 million members. We continue to be encouraged by the performance and growth our healthcare delivery assets. Signify completed its second consecutive quarter of record volume and generated revenue growth of 27% over the prior year. Oak Street also significantly increased revenue in the quarter, growing approximately 32% compared to the same quarter last year, reflecting strong membership and clinic growth. Oak Street ended the quarter with 207 centers, an increase of 30 centers year-over-year. Despite a challenging and dynamic operating environment in Medicare, we continue to see strong profitability of mature clinics and a consistent ramp in profitability of our newer clinics. We are encouraged by Oak Street's performance, which remains in line with our prior outlook, and remain committed to growing our center footprint and expanding access to this leading care model.

Our pharmacy and consumer wellness segment generated revenue of approximately $29.8 billion, reflecting an increase of 3.7% versus the prior year and 6.4% on a same store basis. The primary drivers of this revenue growth were increased prescription volume and pharmacy drug mix, partially offset by continued pharmacy reimbursement pressure, the impact of recent generic introductions, and lower front store volumes.

Adjusted operating income was approximately $1.2 billion. This result was lower than the prior year quarter due to continued pharmacy reimbursement pressure, decreased front store volume, and the timing of certain Medicare payments related to a CMS request. These impacts were partially offset by increased prescription volume, improved drug purchasing, and pharmacy drug mix.

This quarter, same store pharmacy sales were up over 9% versus the prior year, and same store prescription volumes increased by 6.5%. We continued to increase our script share during the quarter, achieving a 27.2% retail pharmacy share. Our results continue to demonstrate we are the best run national pharmacy chain in the country.

Same store front store sales were down by about 4% versus the same quarter last year. Excluding OTC test kits, same store front store sales were down about 2%, reflective of general softening of consumer demand. As a reminder, the public health emergency was active through mid-May last year.

Shifting now to liquidity and our capital position, through the second quarter, we generated year-to-date cash flow from operations of approximately $8 billion. During the quarter, we returned $858 million to shareholders through our quarterly dividend and ended the quarter with approximately $2.9 billion of cash at the parent and unrestricted subsidiaries. We remain committed to maintaining our current investment-grade ratings.

Turning now to our full year outlook for 2024, as Karen mentioned, we are lowering our 2024 adjusted EPS guidance to a range of $6.40 to $6.65 per share. This revision reflects our performance through the second quarter and our latest expectations for the remainder of the year.

Let me walk you through the major drivers of change. In our healthcare benefits segment, we now expect adjusted operating income in a range of $2.25 billion to $2.55 billion. We expect HCB's full year medical benefit ratio to be in a range of 90.6% to 90.8%, an increase of 80 to 100 basis points versus our prior guidance. At the midpoint, our MBR shows a 150 basis point increase from the first half to the second half of 2024, consistent with historical patterns.

In our Medicare Advantage block, first half results remain largely in line with our prior expectations, although they have developed differently than we previously projected. Medical cost trends remained elevated in the second quarter at levels consistent with our restated first quarter experience, which benefited from strong prior period development; however, early indicators for July suggest we may see incremental pressure, particularly in in-patient. As a result, our updated guidance range now reflects the trends in the second half of 2024 could be higher than levels seen in the first half.

It is worth noting that if trends persist at elevated levels, we may be required to take an in-year 2024 premium deficiency reserve in our Medicare business. While this premium deficiency reserve should not have an impact on our revised full year expectations for the healthcare benefits segment, it could change the cadence of earnings between the third and fourth quarters. At this time, we have no expectation that we will need a premium deficiency reserve related to our Medicare Advantage block for 2025.

Our updated guidance also reflects the continuation of the Medicaid acuity pressure we saw in the second quarter. Our teams are working closely with state partners to align Medicaid rates with higher acuity; however, we are assuming no material improvement in the dislocation between rates and acuity through the second half of 2024.

In our individual exchange business, given the magnitude of the negative surprise we experienced in our 2023 update, our outlook now reflects a provision for potential variability in our 2024 risk adjustment position as our data matures over the remainder of the calendar year. As noted, we believe this variability has been appropriately reflected in our recently updated pricing for 2025.

In our health services segment, we are increasing our estimates for 2024 adjusted operating income by a range of $200 million to $250 million, or $7.2 billion to $7.25 billion. This increase reflects the return to strong performance in our pharmacy services business in the second quarter, as well as the continuation of this exceptional execution through the remainder of the year. There is no change to the outlook for our healthcare delivery assets as these businesses continue to perform in line with our expectations.

In our pharmacy and consumer wellness segment, we now project adjusted operating income to increase by $100 million to $150 million, or to $5.7 billion to $5.75 billion. While we recognize that there have been macro shifts in the economic and consumer dynamics, our pharmacy and consumer wellness segment continues to highlight the importance of our community health locations to the consumers we serve, reflected in our growing pharmacy market share. As a result, we are pulling some of the strong first half performance into our expectations for the full year.

Finally, we updated our expectation for cash flow from operations to approximately $9 billion in 2024. This decrease is primarily driven by the timing of reinsurance premiums from CMS primarily related to our standalone prescription drug products, and the impact of lower HCB earnings. The Part D receivable increase will be repaid by CMS during the fourth quarter of 2025. 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 I wanted to provide some updates to our previous expectations for 2025. In Medicare Advantage, we remain committed to driving meaningful improvements in our margins in 2025. As we look at the sources of pressure we discussed in our updated 2024 guidance, not all of these sources will translate into pressure on our 2025 bids. Notably within our 2025 bids, we made meaningful adjustments to our offerings, including supplemental benefits and Part D, both sources of incremental pressure in 2024. We currently project that we will improve Medicare Advantage margins between 100 and 200 basis points in 2025. This will be a significant first step to achieving our target margins of 4% to 5% over the next several years.

For our individual exchange business, we had the opportunity to re-file our bids to reflect the latest risk adjustment data and prudently reflected those updates in our 2025 bids. As a result, we continue to expect profit improvement in that business in 2025. In Medicaid, we believe the dislocation between acuity and rates is temporary and will be largely resolved through the next pricing cycle.

In Karen’s remarks, she highlighted the work our team has underway to deliver on a multi-year enterprise productivity initiative. In 2025, we expect savings from this initiative to drive at least $500 million of adjusted operating earnings. We are encouraged by our deliberate efforts to strengthen our outlook and generate meaningful positive momentum for 2025 and beyond. As is our customary practice, we will give more formal guidance later this year.

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

Question-and-Answer Session

Operator

Thank you. [Operator instructions]

The first question today comes from Lisa Gill from JP Morgan. Lisa, please go ahead, your line is open.

Lisa Gill

Thanks very much, good morning Karen and Tom. I just wanted to start with the health benefits business. If I go back to last quarter and we talked about the level of visibility that you had around cost trends, and then I heard your comments, Karen, that as you closed Q2, the trend accelerated, so really two questions here. One, can you talk about the level of visibility that you have when we think about the trend going into the back half of the year, and then secondly, can you talk about what was included in the 2025 bids? You talked about your level of confidence that you have that you're prudent in those bids, but if you were seeing the trend accelerate coming out of Q2, were you able to capture that in the bids for 2025?

Karen Lynch

Yes Lisa, I'll start with the 2025 bids. I feel like we have a high degree of confidence that we caught the trend for 2025 bids. We took a very prudent approach - we talked about that last quarter, relative to elevated trends and that we expected elevated trends for the rest of the year and into next year, so we feel very confident. I had a cross-enterprise team looking at the bids throughout the entire bid cycle, and we feel good that we'll achieve the 100 to 200 basis points of margin recovery - that's what we expect.

Relative to utilization in the quarter, I'll ask Tom to comment on that.

Tom Cowhey

Hey Lisa. As you look at the trends, there is a lot of things going on inside the quarter. The first quarter re-stated quite positively. A lot of that, we think was a function of change. We actually saw some strong restatement in in-patient in first quarter trends, but then as we looked at what happened in the second quarter, we actually--the Medicare trends quarter-over-quarter, they were roughly flat but at a lower level than what we experienced, or thought we'd experience in the first quarter.

In-patient trends were consistent but at an elevated level, and then we continued to see some elevated trends in outpatient. We saw some pressure in supplemental benefits, such as dental, and also in pharmacy. We also saw some categories such as--we talked a little bit about the outpatient pharmacy, that we had seen that pressure in the first quarter. We saw some positive restatement there and actually some deceleration of trends, which was a nice offset.

Our current outlook, we think prudently incorporates where we are for the remainder of the year, but as you think about the bids, part of the question here is where exactly does this manifest? We had a substantial amount of contingency as we look at our 2024 baseline for those bids, and remember for 2025, we assumed that same level of trend persists for effectively a third year in 2025 at essentially a double-digit rate, very, very high abnormal trends.

When you step back and look at where we've seen some of the pressure this quarter, dental for example has been completely restructured in our 2025 bids, and so if we see pressure there throughout the remainder of the year, it's unlikely to translate. Part D, as we all know, has been completely restructured for 2025, and so we're not--we don't believe that's some of the pressure that we're seeing there is also going to carry over, because those bids have been rebuilt from the ground up.

I would also highlight, you saw some of the changes in CMS Star ratings. We did actually get a nice tailwind in that one of our important HMO contracts done in Florida flipped over to four stars, which will also create an incremental tailwind, and so we feel good about the range of outcomes that we've talked about, 100 to 200 basis points of margin improvement, and there are many scenarios where we think the high end of that range is entirely achievable.

Lisa Gill

Tom, you've talked about membership declines, I think Karen mentioned that today also, and you've said in a public forum up to 10%. Should that be our assumption for '25, that you could lose up to 10% of your membership in MA?

Tom Cowhey

I think when we were out earlier last quarter, we talked about a range of 5% to 10%. That's a good baseline, but I also want to just highlight, why is it that we expect to lose that membership. It's because there were some county exits - that's a small portion of what we think the lost membership will be. As you think about, though, where our assumptions have made some significant dislocation is where we've had--we didn't have a product that we thought we could get back to target margins over the time period that we have, and so we pulled those products, and then we re-filed a new product with a different set of benefits that we would not have been able to achieve by just changing our existing benefit structure.

We believe we've been fairly prudent given the level of disruption that is likely in the marketplace next year and assuming that those terms and resells are going--those resells are going to happen at a much lower rate than what we have historically experienced, but should we see some upside from that, it is likely going to be, in terms of membership relative to that range of 5% to 10% down, it's going to be in products where we restructure the benefits, so we don't necessarily feel that's a bad thing. In other words, I don't know that losing membership is part of the path to profitability, we think that a lot of that has been incorporated just simply into the bid pricing.

Operator

The next question comes from Justin Lake at Wolfe Research. Justin, please go ahead, your line is open.

Justin Lake

Thanks, good morning. First question is on 2025. You previously talked about double-digit EPS growth next year. Is that still the target off your updated estimates, and what are some the key headwinds, tailwinds there beyond the 100 to 200 basis points of MA improvement you're talking about?

Karen Lynch

Yes Justin, thanks for the question. Our goal obviously is double digits, and we're striving to achieve that - that's the goal. We'll provide more detailed guidance later in the year, but let me have Tom walk you through the headwinds and the tailwinds as we think about 2025.

Tom Cowhey

Yes, I talked a little bit about this in the prepared remarks, Justin, but I think just highlighting again, our goal is to grow double digits, but we want to see how the remainder of the year plays out, and we'll provide guidance as we normally do officially later this year.

I would say as you look across the businesses, I just would remind investors that we've seen strong performance in health services, we've seen strong performance in pharmacy and consumer wellness, and we are encouraged by the momentum in both of those businesses. The real question then, of course, becomes Aetna, and so let me break down a couple of the big pieces in there that I think we would like you to focus on.

First, the individual business - we made significant price increases in our baseline for 2025. That is likely to yield a slightly lower membership base, but with a much higher profit margin than where we are this year. When we then learned about how 2023 risk adjustment had backed up on us, we actually--as part of the process when that happens, you actually have the opportunity to re-open your bids, and so we worked with our state partners and we put incremental rate into certain key states after receiving the 2023 risk adjustment update, so we feel good about our ability to make progress there.

In Medicaid, there are price increases that will go into effect on nearly half of our book on January 1, 2025, and we're also--I would say there are some isolated pockets on some very specific issues in certain states, where we're seeing some isolated pressure, and we're working with those states to see what we can do to enhance some of our medical management to try to improve the trend outlook there as well, so we feel good about our ability to improve the outlook for that business. Now, I will also just note, we do have a large win in Texas that will have some start-up costs associated with that next year.

In Medicare Advantage, I talked about this, we did make meaningful adjustments to our offerings. We feel good about our ability to get 100 to 200 basis points in improved margin in 2025, and then if medical costs were to subside from our current outlook, which effectively carries this very high level of trend and then a little more based on what we saw in early July throughout the remainder of the year, if some of that were to subside, there's obviously upside from that because we've been very explicit about what our trend assumptions are.

We have line of sight to over $500 million of incremental cost savings in 2025, and we believe that we have the opportunity to drive $2 billion worth of cost savings over time. Those efficiencies are going to allow us to drive results both for shareholders but also invest in our products, processes, infrastructure. We think these are the right things to do. A lot of them were underway, but we really accelerated our focus on delivering near term value to help improve our outlook.

When you pull all of that together, again we feel like we have a lot of positive momentum. Our goal is to grow double digits and we're going to update investors later this year.

Justin Lake

Then just a quick follow-up on the question around Medicare Advantage. You mentioned, Tom, cost trends elevated, you saw more in July. Where is Medicare cost trend running coming out of July? What are you assuming for the back half of the year, and remind us what you put into your bids for next year relative to that number. Then lastly, can you share just what percentage of members in 2025 in MA will see their products pulled, or have to change products? Thanks.

Tom Cowhey

I'll answer the last one first. You'll have some better insights into that when we see the open enrolment period and the landscape files later this year. Obviously how our membership is impacted is going to be highly dependent on competitor actions, and so we'll give you a better sense on what that looks like later this year.

As you think about medical cost trends, remember there are certain things this year that are specific to some of the pressures this year, and so when you think about trends in the bid, we think about some of the core trends and then we look at some of the things, like supplemental benefits, separately. But we're experiencing all-in, including pharmacy, double-digit trends this year, and when you look at the core trends associated with the baseline in the bids and the baseline that we carried into 2025, it's consistent with the experience that we are seeing year to date, that we've carried through for the next 18 months.

Operator

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

Stephen Baxter

Yes, hi. Thank you very much for the question. I just wanted to ask about the expected MA margin improvement of the 100 to 200 basis points - obviously you'd expected that closer to the 200 basis points range on the last call, so can you just talk about now, seeing where utilization is exiting the quarter, what do you think would get you to the low end of that range and what do you think would be required to drive you towards the higher end of the range? Thank you.

Tom Cowhey

I think there's a wide range on the remaining results for the year, and it's really a function of how much credibility you want to assign to some of the early indicators we saw in July on the Medicare business. At the low end of that range, I think 200 is pressure; at the higher end of that range, I think 200 is very achievable. Really, Stephen, it is a function of where some of the trends over the remainder of the year manifest, so to the extent that they occur in areas where we've restructured benefit, we clearly are going to get a reset off of that, that is not going to carry forward into 2025

I'd just again highlight, though, we believe we've been very conservative in both the baseline and the trend that we assumed in 2025, and so even at the low end of that range, depending on how it manifests itself, we still might be able to get 200 basis points of improvement next year. We really need to see just how the baseline matures over the course of the next couple of months to give you more firm guidance on that.

Operator

The next question comes from Ann Hynes at Mizuho. Ann, your line is open, please go ahead.

Ann Hynes

Hi, great. Thank you. In your prepared remarks, you talked about the retail cost plus [indiscernible] gain in traction with about 2% of claims, I think you said, renegotiated. Can you just give more of an update on negotiations with the last two PBMs, like maybe handicap if you think you'll be able to strike a deal with them? Just any update on negotiations, that would be great.

Karen Lynch

Yes Ann, just a reminder on CostVantage. We really introduced this model to simplify and address the pharmacy reimbursement model, and Prem and the team have been working with PBMs to really contract and address those pharmacy reimbursements and have had success, as I mentioned in my prepared remarks - we have eight PBM contracts already signed and underway.

I'll let Prem talk more specifically about those contracts and where we're headed.

Prem Shah

Yes, appreciate the question, Ann. Look - we continue to have active, productive discussions with our large PBM partners and continue to make progress in transitioning all of our commercial contracts for January 1, 2025. At the end of the day, if you think about the retail pharmacy reimbursement landscape and how it works, what we're doing with CVS CostVantage allows pharmacies to be reasonably compensated for the care and the value that they provide in the local communities, so I would say more to come in the next couple quarters, but we remain positive about where we stand at this point with CVS CostVantage and how it's resonating in the marketplace.

Operator

The next question comes from Eric Percher from Nephron Research. Eric, your line is open, please go ahead.

Eric Percher

Thank you. I'd like to ask for a little bit more on the Part D marketplace, given the initial bid direct subsidy exposure and the demo program. Can you give us an idea for your response to that program, does the Part D demo help to de-risk this marketplace?

Karen Lynch

Eric, we're really pleased that CMS has offered this Part D program to really stabilize the Part D premium. We have applied for the demonstration and are looking forward to working out the details, but we really do think that this was the right answer and we're very pleased. We were talking with CMS over the course of the last several months, we felt like we had influence over that and feel good about what we were able to accomplish.

Operator

The next question comes from Michael Cherny from Leerink Partners. Michael, your line is open, please go ahead.

Michael Cherny

Good morning, thanks for taking the question. Maybe to go back to Ann's question and ask it from a different direction, seeing nice traction obviously on CostVantage, and the logic behind that is fairly sound. Is your intention, if you don't get full compliance from the remaining almost 50% of the plans in place, that you're going to have a dual reimbursement structure on the commercial side, and how exactly will that work functionally for the organization in terms of your pricing mechanisms, your sourcing, etc.?

Tom Cowhey

Today we have multiple reference price models in the marketplace with payors. Our intention is to move all of our commercial contracts, as I stated previously, to our CostVantage model. It benefits both payors and us in the predictability and the way cost of goods are passed through, and provides predictable, what I would say is reasonable margins for the pharmacy as it relates to that. Our expectation is that we will move the commercial market over to this.

We will still have a dual market, right, because the Medicare and Medicaid contracts still exist on another platform, and as we've said prior, we're going to move the commercial marketplace over on 1/1/25 and follow that with the Medicare and Medicaid markets at some time in the future. From my perspective, we'll be able to handle that, but our expectation is that we're moving the commercial marketplace over for 1/1/25.

Operator

The next question comes from Elizabeth Anderson at Evercore ISI. Elizabeth, your line is open, please go ahead.

Elizabeth Anderson

Hi guys, good morning, and thanks for the question. Maybe just to piggyback one more off of what Mike was just saying, is your expectation for those contracts, the commercial contracts that you've moved over for 1/1/25, that those would have flat margins versus 2024?

Tom Cowhey

Yes, we're not providing guidance at this point. Our expectation is to, as we've said over the long term, if you think about what's happened with reimbursement pressure going all the way back to our analyst day, we've talked about how it's been a headwind for retail for a very long time in this industry. What CVS CostVantage will do is over time, it will flatten that out to basically allow payors to have the benefits of our industry-leading cost of goods to get passed through in a more transparent fashion, and flatten out the reimbursement pressures over time.

We haven't provided 2025 guidance yet, but the expectation of CVS CostVantage is to really do that over time and provide a floor in retail.

Karen Lynch

I might ask David to talk a little bit about how that's translating on the PBM and the TrueCost and how that's flowing all the way through. David, why don't you take it?

David Joyner

Yes, so Elizabeth, I think it's important that you see both sides of the equation. There's clearly recognition that there are pain points in today's price model, so you have this average market basket pricing and what we see in cross-subsidization, so both what Prem is solving for on the retail side is exactly what we're solving for in our TrueCost model with our clients.

The fact is that we're hitting what I believe are the issues head on by trying to drive a new price model that both serves our customers in eliminating the price variability, and creating more simplicity and transparency at the member or the consumer level. The good news is that we've launched TrueCost for our employees on 6/1. We launched it, what we believe is very successfully. It helps create a platform and a demonstration that the product will actually work effectively for members on a high deductible plan, and we're also beginning to evolve this and roll this model out to the rest of our book, so we're looking obviously at waves or attributes of the model and we suspect that we will have close to two-thirds of our customers on at least a couple of the attributes as we try to rebalance and create more transparency at the member level.

We feel really good about the fact that we're aligning both what's happening at retail and how it then connects with how we're basically driving the model in the payor community.

Operator

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

Kevin Caliendo

Hey guys, thanks for taking my question. If I'm just thinking through some of these--some of what we learned today, right - we have $500 million in operating savings that will flow through next year, we're going to have 100 to 200 basis points of margin in MA, you have cash flow, you also have some benefits potentially from HIX. All of those combined are well in excess of what would be 10% earnings growth off this new base, and that's not even including Stars. I'm just wondering, is your expectation for Stars still the same as it had been, the Stars benefit in 2025? Is there anything that changed there? That's my first question.

Karen Lynch

Yes, nothing has changed relative to our Stars. It actually improved given some of the changes that occurred earlier this quarter, and Kevin, you described what we feel is very positive momentum going into 2025. As both Tom and I talked about, we feel good about 2025 relative to that positive momentum; in addition, we have very strong retention in our Aetna book and in our CareMark book relative to client accounts, so generally speaking we feel good about 2025. But as Tom said, we want to see how the rest of the year plays out before we give formal guidance for 2025, which is typical of what we do anyway.

Tom Cowhey

Kevin, one just point of minor clarification, the 100 to 200 basis points has always been inclusive of the Stars tailwind next year, but as you think about some of the pressures that we've seen or could see, based on what we've heard and some of our early reads in July, really as we think about what's happened in June and get more data there, one of the positive offsets to that potential trend inside that range is further momentum on Stars because of that change, particularly to our Florida HMO contract.

Operator

The next question is from Lance Wilkes from Bernstein. Lance, your line is open, please go ahead.

Lance Wilkes

Great. Can you talk a little bit about the leadership changes for Aetna, in particular with you taking control of that, what are the changes and priorities you're going to be establishing there, and what are going to be some of the changes in management processes and any sort of org changes, and how much of the $500 million of incremental cost savings that will fall to the bottom line would come through Aetna? Thanks.

Karen Lynch

Thanks. As you asked, the financial performance of this business was not meeting my expectations and I decided to make a change. Relative to the priorities there, I will be establishing a very strong management process, driving execution of improved financial and operational performance, and those will be my key priorities.

Tom Cowhey

Lance, just one quick follow-up, we're not parsing out where some of the $500 million in synergies comes from - that's all bottom line. A reminder, though, as you think about 2025, we do have some expenses that are deferred, that will come back in 2025, and this will at that level help to offset that. We're not done yet - we're still working through what other opportunities we have this year, so I think of that as a floor that will help to improve the outlook for next year.

Operator

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

Charles Rhyee

Hello, yes. Thanks for taking the question. Karen, I wanted to ask, you mentioned earlier about the way that CareMark health saves money and the role that PBMs play in really lowering drug prices for both employers and consumers. I get all that, and obviously we can debate the issues within the FTC interim report, but what does seem clear, though, is that that message doesn't seem to be resonating, particularly on the Hill, and certainly when you look at how the media portrays the PBM industry, can you talk about what CVS is doing, maybe in conjunction with PCMA to really kind of amplify the message of the PBM industry, and why has that not resonated or has that not gotten through to folks, particularly the FTC let's say ahead of this interim report, to kind of understand the role that PBMs play, and what can we do about that? Thanks.

Karen Lynch

Yes, I think a couple things. One, we've taken a very aggressive approach to educating Congress on the role of the PBM. We've been doing a lot relative to communications. One of the things that--you know, both David and I have spent a lot of time on the Hill, and what we realized, it is an education thing, and we've been amplifying our message and you can see that.

What I would say is that we have demonstrated and proven over time that we are saving money, and the results reflect that. I think the FTC was very targeted - you know, they took certain data and not the holistic data to really amplify their story versus the real story, and we feel confident that--you know, we continue to have discussions. As you can see, nothing has happened in Congress because there's a lot of discussion going on around the PBMs. I do think that, if anything ever does happen, it will be on transparency, but we continue to drive and educate Congress, and that's what we're doing, and continue to--.

I'll ask David to see if there's anything else he wants to comment on here.

David Joyner

Maybe just to reinforce, Charles, this has been an industry that continues to innovate, adapt and evolve, and I think we're listening to the critiques and/or the concerns, and just to look specifically, what we're seeing in DC, the focus is for the most part what the out-of-pocket costs are for members - that is the consumer, and when you look at 90%-plus generic dispensing rates and average out-of-pocket costs of $8, and actually that cost is actually less than what it was in years past, I think we're doing our job.

To your point, the message has not resonated as effectively because everybody is focusing on the high cost of brands, which is what we're solving for specifically with our customers, so that last 10%. If you look specifically at what we did with the biosimilars, we were the only PBM and we've actually got a lot of credit and recognition for this in both DC and among our customers, and that we saved $400 million-plus by converting a high list price Humira brand to a low list price product to save our customers money, and then the members ultimately ended up paying close to zero dollars out of pocket.

If you demonstrate the fact that we are evolving and continuing to create value for our customers, which results in a high retention rate and a high growth rate, then our customers will ultimately begin to create the voice for making sure that they're protecting and actually continuing to--you know, what I think is reinvest in the things like the PBM tools and the programs that we've delivered in the past.

I think the last piece I'll just say, which I mentioned earlier, is that the price models need to evolve. Prem has recognized that at retail, and I think within CareMark on the PBM side we recognize the need to continue to evolve the price model, which is why we believe TrueCost is critical for the future success and what I believe is the transformation of how pricing ultimately is delivered both to the customer and ultimately down to the consumer.

I think the facts remain clear - the PBM industry and specifically CVS CareMark creates significant value, and I think once the actual empirical evidence is there and actually begins to get passed into those that are actually at the legislative branch and ultimately those that are actually writing about this industry, that the numbers will speak for themselves.

Karen Lynch

Yes, and I just want to emphasize the point that David made - you know, we are leading the industry in changing the way pricing is done, both at the retail counter and through CareMark, and I think that we've set the standard for future innovations, and I think that's an important part to changing the dialog and the landscape in this business.

Operator

Our final question today comes from Brian Tanquilut from Jefferies. Brian, please go ahead, your line is open.

Brian Tanquilut

Thanks. Tom, maybe just as I think about the revised guidance, obviously you've adjusted it a few times already, how would you get investors' confidence that this is the right number at this point, that you've baked in enough trend and prudent conservatism, and maybe any color you can share on what buckets of in-patient you saw the trend uptick in July. Thanks.

Tom Cowhey

Sure Brian, thanks for the question. Maybe just let me take a step back and just talk about the quarter, because I think as you look at the quarter, it looks stronger than I think it is. We had $150 million worth of prior year reserve development, we had strong prior period reserve development off the first quarter, particularly as claims normalized after the Change cyber attack. We had some revenue pick-up in Medicare, we had some positive provider settlements. Going the other way, we had to increase the risk adjustment payable, but there's more positives than negatives as you look at the quarter, which I think got us to the printed results inside the quarter but really masked some underlying pressure.

We took the opportunity to really step back and re-evaluate what we saw in the second quarter, and really over the full first half now that we have a more complete period, and really tried to pull that forward into the remainder of the year. If you look at the last five years at the very highest level, you say the MBR tends to pick up the back half, how much was the pick-up? So off a printed first half, you tend to see four out of the last five years, the one exception being 2020 when COVID really masked the underlying trends, you see 150 basis points of pick-up in the MBR in the back half - you know, deterioration that goes up the MBR. At the midpoint, that's exactly where this guidance is - that's at the very highest level. I hope that that should give investors some confidence.

Then as you look at the specific risks, what we've done is we've taken the presumption that the trends in Medicare that we've seen throughout the first half, that they will persist throughout the remainder of the year and that they could modestly increase. As we noted, the first quarter did restate positively, but we continue to see elevated medical cost trends in the second quarter and we did have some indications of pressure in July. We don't believe that that is an increase into midnight [ph], it's just we've seen broad-based in-patient pressures. The range of outcomes for the remainder of the year on the Aetna business is primarily driven by a very early read on an uptick in a long July, so that's part of the reason for the range, is to try to incorporate what some of that variability is off a very early indicator.

In our exchange business, our outlook incorporates the potential for additional risks over the remainder of the year, particularly if we're not successful in maintaining our risk adjustment trajectory on the 2024 block, and lastly, we incorporated the risk that the dislocation between Medicaid acuity and rates that pressured us inside the quarter persist throughout the remainder of the year.

Maybe the easiest way to think about it is at the low end of that range, the AOI range for healthcare benefit, the risks are probably all roughly equivalent in magnitude, and they're really the primary drivers of the change in outlook. We think that we've captured it, but we're obviously watching the data very closely but we tried to incorporate as much prudent into the outlook as we thought was appropriate.

Karen Lynch

Thank you for joining our call today. I want to take the opportunity to thank all of our colleagues for their continued contributions and working to improve the health of all the people that we serve. 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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