The Economic Club of New York

Breakfast Series

Larry Merlo
President and Chief Executive Officer
CVS Health

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Interviewer: Susie Gharib
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Introduction

Barbara Van Allen, President of the Economic Club of New York

I'm Barbara Van Allen. I'm President of the Economic Club of New York. Our Chairman, Terry Lundgren, had to travel this week so he asked me to do the honors. It's my pleasure to introduce our guest speaker this morning, Larry Merlo, President and CEO of CVS Health. As you all may know, it's quite a large company with $177.5 billion in net revenue for 2016. It touches more than 100 million people each year through its unique combination of assets, including more than 9,700 retail pharmacies, 1,100 walk-in medical clinics, a leading pharmacy benefits manager with nearly 90 million plan members, a comprehensive provider of pharmacy services to long-term care facilities, and expanding specialty pharmacy services.

Under his leadership, the company is working to transform healthcare by delivering breakthrough products and services that enable people, businesses, and communities to manage health in more affordable, effective ways. As part of the commitment to public health, in 2014, the company announced the landmark decision to be the first major retail pharmacy to eliminate tobacco sales in all its stores. And to reflect the broader healthcare commitment of the company, they subsequently changed the corporate name to CVS Health.

So, Larry is a pharmacist by education. He joined CVS Pharmacy in 1990 through the company's acquisition of Peoples Drug stores, which I grew up going to here in the Mid-

Atlantic. Prior to assuming the role of President and CEO in 2011, he held positions of increasing responsibility, most recently President of CVS Pharmacy. Under his leadership, the company has completed a series of highly successful acquisitions and delivered significant organic growth in major markets across the country. A graduate of the University of Pittsburgh School of Pharmacy, Larry serves on the Board of the National Association of Chain Drug Stores and the University of Pittsburgh Board of Trustees. He's also a member of the Business Roundtable.

Today, our format will include some opening remarks from Larry, followed by a Fireside Chat with our Club member and Fortune - Time anchor and special correspondent, Susie Gharib. We'll reserve, as we always do, 15 minutes at the end of the program for questions from our members and their guests as is our practice at breakfast. Please keep in mind that the program today is open to the media. We do have media at the back of the room. It is on the record. And be assured, as always, that we'll wrap up promptly at 9 a.m. Larry, the podium is yours. (Applause)

Larry Merlo
President and Chief Executive Officer
CVS Health

Good morning everyone. And thank you, Barbara, for that kind introduction. And, you know, certainly the Economic Club of New York has a very long history of promoting serious

discussion on some of the most important economic, social, and political questions of the day. And it's certainly an honor for me to be able to be here with you this morning and share my thoughts on some of the pain points that exist in our country's health care system.

And I'll start with the fact that the current system was built to provide acute care in a fee-for-service world – not to provide coordinated care to the chronically ill, who now make up about one-half of the U.S. population. Nor was it designed to meet the changing demands and expectations of patients, who are increasingly looking for more value, greater convenience, and more help in making healthier choices every day.

And the result of all of this is a fragmented system that has produced high costs and, let's call it, not so good health outcomes, and one that many patients experience as a maze of confusion. And many of you have experienced these challenges, not only as patients or caregivers, but also as business leaders and employers.

So, today, I thought I would focus on three of the more significant pain points and that's the rising costs of health care, the challenges in accessing primary care, and the growth of chronic disease. In addition, I'll discuss some of the shifts that are needed to improve outcomes and drive down spending, and some examples of some sensible, market-based approaches and opportunities to do so.

So, let me begin with that first pain point – rising costs. If you go back and look at health care spending, health care spending as a percent of GDP, it was 5% back in 1960. And today it's on a trajectory of 18%, you know, approaching 20% within the next ten years. That extra two percentage points would amount to more than $250 billion, undermining our country's ability to fund every other critical priority, whether it's education and infrastructure. Certainly that list goes on. And these cost increases have a huge impact on the budgets of employers, public programs, and they are increasingly affecting the pocketbooks of everyday Americans. And here's why.

First, employees' health premiums have been rising at about twice the rate of salary increases. Second, more employees are enrolling in what is referred to as high-deductible benefit designs. And, you know, today, nearly 30% of covered workers are enrolled in high-deductible plans, and that compares to about 4% a decade ago.

And these plan designs are intended to introduce more consumerism into the health care system. However, you think about approaching health care with a consumer mindset, that's a very, very new experience for many people. And what people want is affordable health care, and they need innovative tools, as well as simple and clear information, to help them be more effective health care consumers.

So, maybe said another way, I think we've pushed, you know, health care accountability and

decision-making towards the patient, but health care literacy and the tools to empower patients are lagging behind the expectations of consumer-driven benefit designs.

Now, since medications are involved in about 80% of all health care treatments, one significant opportunity to lower costs for consumers is the way in which prescription drugs are procured, priced, and managed. If you look at the pharmacy landscape today, more than 87% of prescription drugs dispensed all across the country are generics. And if you look at the average out-of-pocket costs for one generic drug, that may be taken as part of a chronic disease, as part of one's daily regimen, you know, the annual cost to that patient is less than $70, annual cost. And we've heard a lot about prescription drug pricing, so you turn around and say, wait a minute, less than $70 for a year, 87% of the prescriptions, so what's the problem? Well, the real problem relates to that other 13%, which are brand-name drugs.

And pharmacy benefit managers, or commonly referred to as PBMs, they do an effective job in driving down drug prices for their clients, whether it's an employer, health plan, or government clients. And, you know, over the next decade, PBMs are projected to save clients more than $650 billion on drug costs. And they do this by leveraging the purchasing power of millions of Americans and by deploying a variety of tools and capabilities to ensure that their clients and their clients' members receive the right pharmacy care at the lowest possible cost.

Now, traditionally, physicians have not had visibility into their patients' benefit plans to know what programs are available for each of their patients or the costs associated with, you know, the

various medication options, or where patients may be at in their deductibles. And with the growth in our business of electronic prescribing and electronic health records, you know, that's no longer the case. It is now possible for PBMs to transmit important benefit and formulary information to both the patient and the physician through the patient's electronic health record. You can provide, you know, drug pricing and other valuable data at the point of prescribing. And this creates an opportunity for more informed dialogue about the most appropriate course of treatment, which can prevent what we refer to as "sticker shock" that many patients experience today at the pharmacy counter when they go to have their prescription filled.

And it's bigger than just pharmacy, you know, there are similar opportunities that exist across the entire health care system. Take MRI scans as an example. According to data that has been compiled by Medicare, an MRI could cost you as little as $470, or as much as $13,000, depending on where you have it performed. At the same time, there are billions of private-sector dollars being invested in developing more cost-effective comparison tools and other technologies, whether it's mobile applications, wearables, cloud-connected devices. And all of this is intended to help individuals and their physicians make more-informed decisions about health and their health care.

And as patients continue to take advantage of these new tools and act more like consumers, they will help spur even greater competition among health care providers, and we think that that will go a long way in helping to lower the overall cost of care.

A second major pain point – access to primary care. You know, most experts agree that primary care physicians should serve as the medical home for all patients. However, the expansion of health coverage as part of the Affordable Care Act, and 10,000 Americans reaching retirement age every day, and that's going to continue to another decade, you know, the system is becoming overwhelmed by the increased demand for service.

In just the last three years, the average wait time for a physician appointment in large metropolitan areas has increased by more than 30%. And it's projected that by 2020 – it's only three years away – that the U.S. will experience a shortage of more than 45,000 primary care physicians. Making matters worse, patients without a primary care physician, or who simply can't get an appointment, what do they do when they're sick? They often turn to the least cost-effective site of care, and that's the emergency room. So, clearly, there's an opportunity to help consumers more easily access health services, whether it's in their communities, in their own homes, or through digital tools.

And that's why one of the most encouraging changes taking place in health care today is the expansion of lower-cost sites of care. We've been calling this the "retailization" of health care, and we think it's just getting underway. You know, as an example, urgent care centers, walk-in health clinics, they're growing rapidly. They're up to 80% less expensive than the emergency room for the services that they provide, with the same or even better outcomes. We think this

makes them an ideal complement to primary care.

Another convenient option is in-home care, where treatment such as infusion services can be provided at a much lower cost than at a medical facility, and with greater comfort for the patient. And, as the population ages, we think this will become an increasingly attractive option for those who prefer to, let's say, age in place.

The next frontier of accessible care is telehealth. Imagine how different, you know, our health care system will look when millions of Americans can use an app on their phone to teleconference with a physician from, maybe a walk-in clinic, or perhaps their home, or maybe a hotel room, you know, halfway around the world. That's where health care is headed, and the future is not that far off.

I do want to emphasize that these additional care options do not replace primary care physicians. They complement and extend primary care. In addition, it's critical that the care provided through these and other low-cost sites be connected and integrated through the patient's electronic health record to avoid the risk of fragmented care.

So that leads me to the third and final pain point, and that's the growing prevalence of chronic disease. You know, I referenced earlier, today 1 in 2 Americans have at least one chronic disease such as heart disease, hypertension, diabetes, and the numbers are growing. Today, it's estimated

that more than 80% of all health care spend goes to treating chronic illnesses. And ineffective management of these conditions, and the medications associated with them, is estimated to cost more than $300 billion per year in avoidable costs. For example, research indicates that about half of all patients in the U.S. do not take their medications as prescribed, and up to a third of prescriptions that are written never even get filled.

This leads to, as you would expect, some serious consequences. Today, about 1 in 5 patients who are discharged from the hospital are readmitted within 30 days. About 3 in 4 of these re-admissions are preventable and 2 in 3 actually relate to a medication issue. This is simply unsustainable, particularly as the population ages and more Americans transition across care settings, such as the hospital, or the home, or into some long-term care facility.

So there is a tremendous opportunity to make health care much more effective, by engaging with patients more frequently where they are, and coordinating care to make a complex system much easier to navigate. And we certainly see pharmacy care playing a significant role. You know, if you think about a patient with a complex disease like diabetes, they will visit their pharmacy more than 30 times a year. That same patient, if they see their physician on a quarterly basis, 30 times in the pharmacy, 4 times in the doctor's office. So pharmacists can play a more active, supporting role in each person's unique health experience, from advising them on the best use of their medications and improving medication adherence, or helping to coordinate care more effectively among a patient's health care providers.

And research has shown that programs that include one-on-one counseling between patient and pharmacist are two to three times more effective at improving just medication adherence than any of the other interventions that are possible and they result in cost savings of about $3 for every $1 invested. In addition, the ability to analyze big data has enabled interventions in pharmacy care that can support pharmacists in ensuring that patients receive high-quality care. At CVS Health, as an example, we have developed what we refer to as the Health Engagement Engine. And this engine, you know, not only analyzes our own pharmacy data, but it also looks at data from other payor sources, including health plans, providers, and health systems.

This creates a much more holistic view of the patient, along with the ability to exchange information with the insurer and the physician through the patient's electronic health record. For example, we can notify doctors when patients are not refilling their prescriptions, and doctors can alert us to patients who have some very complex regimens where we may be able to provide more support by helping to synchronize all of their prescriptions onto a common fill date.

We've even developed a pretty accurate way to predict when fragile patients might need extra support, such as when they're about to be discharged from the hospital or transitioning perhaps into a skilled nursing facility. By intervening at these critical moments, we can help prevent some of those costly re-admissions that I alluded to earlier.

Now, utilizing this data is, we see it as a crucial opportunity in health care today. You know,

today I would describe the system largely analyzes data reactively to determine the cause of a health event after it occurs. Going forward, the ability to translate data into actionable information proactively – predicting and preventing events before they happen – I think that will really start to move the needle in a way that produces better outcomes at a lower cost.

So, let me conclude where I began, okay. And that's that the health care system that we have today, it wasn't built to adequately address the pain points that are all too familiar to us. And fortunately, there are many opportunities to improve outcomes and drive down costs, and I am optimistic about the changes that have been taking place.

At CVS Health, you know, you think back to, you know Barbara describing the capabilities that we have, we think of ourselves as being the front door to health care. We touch the lives of 1 in 3 Americans, and we're playing an active role in providing more affordable, accessible, and effective care. And we're not alone in this effort. There are tremendous investments that are being made in private-sector innovation to improve health care and reduce spending. And market forces are helping to increase choice and competition, empower patients as consumers, and to make this complex system easier to navigate.

At the same time, there are important public policy changes that can be made to help accelerate these opportunities. And just to mention a few, let's continue to increase competition in the prescription drug market. Today, there is a backlog of more than 3,000 new generic

pharmaceuticals that are awaiting approval by the FDA. Giving priority review to drugs for which there's no competition, and increasing speed-to-market of new biosimilars. And I know the new FDA Commissioner, Dr. Scott Gottlieb, shares these priorities, and I applaud him for the actions that he has been taking.

Second, let's accelerate consumerism by modifying the rules around health savings accounts. I know many in this room, you probably have that as part of your health insurance. Currently, the rules allow employers to cover certain preventive drugs for chronically ill patients at little or no cost outside of the patient's deductible. However, patients are required to start paying for their drugs as part of the deductible once they get sick. Now, you may be sitting here at this point saying, Larry, you got that backwards. No, I didn't get it backwards. And, you know, we believe that plan sponsors should have the option to cover all prescription drugs for little or no copay outside the deductible at any time, if that is how they choose to structure their benefit.

Now third, given the importance of their role, let's empower pharmacists to spend most of their time taking care of patients, not doing administrative work, and allow them to practice to the top of their license.

I know all of you have a huge stake in the debate over the future of health care, so I hope you'll stay actively involved.

Before I conclude, I want to say a word about a very important topic in health care, and that's the alarming and heartbreaking opioid epidemic. In the last two decades, opioid prescribing rates have increased nearly three-fold. This remarkable volume of opioid prescribing is unique to the United States, where prescribing in 2015 was four times what it was in Europe. This epidemic has no single cause. It doesn't discriminate. It exists in our cities, in the suburbs, across rural America – among all socio-economic groups. And addressing it requires a multi-pronged effort involving all health care stakeholders, whether it's physicians, dentists, pharmaceutical companies, pharmacies, insurers, and government officials.

At CVS Health, we will continue to be actively engaged and do our part. You know, in the last two years we've worked with local law enforcement across the country to collect and safely dispose of what now amounts to more than 100 metric tons of unwanted medications. And next year we'll double-down on these efforts installing another 750 drug disposal collection units in retail pharmacies across the country. We've worked and partnered with now more than 43 states to expand access to the opioid overdose-reversal drug, naloxone, to help save lives and give people a chance to get the help they need for recovery. We also have a program that we refer to as "Pharmacists Teach." We have 30,000 pharmacists all across the country, in local communities across the country. And these pharmacists go out into their communities, into the schools, to educate students about the dangers of prescription drug abuse. And to date, we've now touched more than 300,000 students through this program.

One of the most difficult challenges, however, is changing prescriber habits for – I'll call them – acute injuries. How many of you have had the experience where maybe it was a dental procedure or some acute, you know, ankle injury, knee injury, and you've left the office with a prescription for 30, 40, 50, 60 powerful pain pills? And I see a lot of head nodding. As a leading stakeholder in pharmacy care, we believe it is time to institute limits on the quantity of opioids dispensed to patients who are receiving opioids for the first time and to ensure that the prescription fits the medical condition. So, utilizing our retail pharmacies and our PBM services, we will work with physicians, patients, plan sponsors, and other stakeholders to limit to seven days the supply of opioids dispensed for those certain acute prescription needs, while continuing to ensure that patients that have critical chronic needs will continue to have access to appropriate care.

So, thank you again for the opportunity to share my thoughts with you, and I look forward to the discussion with Susie. (Applause)

FIRESIDE CHAT

BARBARA VAN ALLEN: Thank you, Larry, for those insightful remarks, and we'll now start into the Fireside Chat.

SUSIE GHARIB: Thanks Barbara. Larry, I'm sure everybody in this room has a personal story that they could tell you about their pain points, so thank you so much for your presentation. It

was really great. I'd like to pick up on where you just left off on this opioid crisis and the new policy that you've put in – seven days' limit on a prescription as opposed to the 18-day, 20, 30, whatever it's been. So, it's been a couple of weeks since you announced that. What kind of reaction have you been getting, whether it's from doctors or patients or other drug makers?

LARRY MERLO: Susie, it's a great question. And if you go back, and I think one of the things that we've learned, you know, I talked about what we've done around drug collection – empty out those medicine cabinets. And I think one of the things that, you know, it hit us, I think we were all shocked. Over 100 metric tons, that's over 200,000 pounds of unused medication. So, you know, you sit here and say, well, if we could go and empty every medicine cabinet in America, by the time we're done it'll be time to start over again because we have not solved for the root cause. Why are these meds there to begin with? So, that was really the trigger point in terms of how do we get to the root cause? And the root cause is, you know, the prescribing habits that physicians have gotten – and dentists – have gotten accustomed to automatically writing for that quantity of 30 or 60. So that's how all of this began. I would say we've had a tremendous outpouring of support, and we've gotten countless emails from our customers who want to share their story, and many of them are heart-wrenching, okay. Susie and I were talking earlier, I got an email from a mom who talked about her son who was a football player and got a football injury, went on an opioid, became addicted, and he's now in his late 20s and he lives with that addiction challenge every day. He's been into recovery multiple times. And she went on to describe, you know, stick to your guns because we've got to change this for the next family that

might incur the same scenario. So we've gotten those responses. We absolutely want to work with physicians because the challenge in this is how do you separate the acute need, okay, from, you know, perhaps that cancer patient, or that person who has chronic needs? And that's why this is a collaborative effort between our retail pharmacies and our PBM services that we're confident that we can ensure that, again working with patients and physicians, that we can identify the right people who we can start with a 7-day supply.

SUSIE GHARIB: So you're saying it was pretty supportive. Was that the reaction you were expecting?

LARRY MERLO: Yes, Susie, I think that we expected that there would be a lot of questions in terms of how are you going to do this so that we don't deny care, okay, to those patients who need it? We're comfortable that we have an answer around that. Listen, every day this is in the news. I think people are looking for a solution. Much like we talked here, I saw a lot of head nodding and a lot of hands raised. I think everybody can relate to the fact, those circumstances where you left the doc's office and why am I sitting here with 30 tablets? I don't need them. So, I think we expected that type of reaction and that's what we've seen to date.

SUSIE GHARIB: What about from other pharmacies? Are they going to follow your lead?

LARRY MERLO: Yes, Susie, it's a great question. You know certainly I think other companies

are going to have to make the decision that they believe is right for their business. I will say that this is not a competitive issue. We have had discussions with our competitors – both on the retail pharmacy side as well as on the PBM side – that, listen, working together with a common cause, we can make an even bigger impact. And there's a lot of discussion taking place there. So, Susie, I have optimism that we're going to have others join us in this regard.

SUSIE GHARIB: But, in your experience, when you decided a couple of years ago to remove cigarettes and tobacco sales from inside your CVS stores, there weren't many fast followers that copied you. Now, cigarettes is a serious health issue, so are opioids. Do you think this time it'll be different? Do you think you'll get a different reaction from other pharmaceutical, you know, drugstore chains, and whatever?

LARRY MERLO: You know, Susie, again, I would hope so, okay, because it's simply the right thing to do. I think on the tobacco decision, listen, we knew that that was the right decision for our company as we were becoming more of a health care company. And I see my good friend, Mark Bertolini from Aetna here, and I remember Mark and I talking about that decision that, how do you have credibility to do all the things that we talked about this morning, and at the same time you're delivering health care in the back of the store and you're selling tobacco products in the front of the store. And we saw that as a credibility and an integrity issue in terms of what we were doing and what we were becoming and evolving to as a company.

SUSIE GHARIB: I want to stay on this just a little longer, push you a little bit more about have you talked to your competitors, like Walgreens or Walmart, about your announcement, and hey guys, are you going to do the same thing? Come on, step up.

LARRY MERLO: Yes, Susie, we have had those discussions.

SUSIE GHARIB: Since your announcement?

LARRY MERLO: Well, actually leading up to the announcement and we've talked about it as part of the trade associations that exist, both on the retail side as well as the PBM side.

SUSIE GHARIB: So what do they say?

LARRY MERLO: I think there is a lot of discussion taking place in their respective offices in terms of what they should do. As I mentioned earlier, I can't speak for what they will do, but I think there's optimism that we need an industry solution. And it will be better for all of us if we can, you know, develop a singular solution. And I think it'll be much easier for everyone to rally around and to execute.

SUSIE GHARIB: And so this whole thing kicks on February 1, 2018, so there's some time to work it out. So, how is this going to work? A patient goes into the, comes into CVS and says I'm

going to, my doctor gave me this prescription but it's for more than seven days, then what happens? You're going to call the doctor, and what is the doctor going to do? Are you guys going to have to battle it out?

LARRY MERLO: Yes, you know what, Susie, I don't know that I'd look at it as a battle, okay. And again, I think that using the services of our PBM, okay, that will be important in terms of understanding this is a chronic needs patient, you know, this patient is a first-time opioid user. So I think that's an important dynamic. I'm optimistic that as this begins to gain traction in the marketplace, I do see prescriber habits beginning to change. I know I've personally had a number of discussions with some physicians that I know. And it kind of falls under the heading of just kind of force of habit in terms of what they've been accustomed to. So I think it will take some time, but I do believe that, you know, at the end of the day, we will make a meaningful difference in what we're doing.

SUSIE GHARIB: So you said in your talk that this is going to require a multi-pronged effort. So you took the first bold step here. What's the next step?

LARRY MERLO: That's a great question. And, Susie, I think that we think about our actions being focused on prevention, education. You know we talk a lot about collection and partnering. And I think we'll continue to get learnings, okay, as we do more things. And it's hard to sit here and say what's next, but I think as an industry and as being one of the stakeholders, okay, that

has a responsibility for developing solutions, I don't think we can rest until we know that this trend is not accelerating, it's beginning to decline. And listen, one of the things that we have seen from the actions that we have taken over the last four years is we've seen a decline in the number of opioid prescriptions that we've dispensed in our pharmacies by as much as a third. So we know the actions that we have taken to date have made a difference.

SUSIE GHARIB: So I understand that New York Attorney General Eric Schneiderman has contacted you, contacted CVS. What role can he play? What can he do in your efforts to move this along? You said earlier that government officials have to get involved in this.

LARRY MERLO: Yes, Susie, there are a number of opportunities out there. We talked a lot about, I mentioned electronic prescribing, and today, about 65% of all prescriptions that are written, you know, get to the pharmacy through electronic prescribing. We know that is one of the best methods with which to reduce the risk of fraudulent use. So mandating electronic prescribing of all controlled prescriptions, that would certainly support everyone's efforts. I think the other thing that exists, and it's referred to as prescription drug monitoring reports, or programs, they exist at the state level. And a pharmacist can go one of those reports and to see if this particular patient has had multiple prescriptions from perhaps multiple pharmacies, and they're clunky to use. I think the big challenge around that is they exist at the states. There's no national program and there's no national standard. So, the ability to enjoin these state programs around a common solution, you think about the border towns and states, and it becomes very,

very difficult for a pharmacist to be able to triangulate when, oh, gee, I might have to access three or four different states', you know, monitoring programs, to answer a simple question. So, I think those are just a couple of examples in terms of how government officials can help move some things along. But we know we'll make a difference.

SUSIE GHARIB: So I'd like to move along to drug prices, and I'm not going to get into the whole sticker shock and he said/she said, what the drug makers say about the PBMs and what the PBMs say about the drug manufacturers. But I do want to talk to you about Amazon. The word is that Amazon could be getting into the pharmacy business and selling drugs online. What do you think about that?

LARRY MERLO: Well, listen, we have, as an industry, we've seen new competitors enter and emerge. You know, I will say, and listen, Amazon obviously has become, in many households across the country, and listen, they do a great job. They have changed how America thinks about shopping and have defined convenience perhaps, you know, in different ways. For many of the reasons that I touched on earlier, pharmacy is, you know, we shouldn't confuse pharmacy with a book, okay, or a product. There is a service component to pharmacy that, that is very different. And the barriers that exist, or the barriers to entry, okay, with pharmacy are different than, you know, what you might experience with other products.

SUSIE GHARIB: So, are you saying that it's going to be difficult for Amazon to come in and

disrupt the drug selling business compared to the food business or any other area that they get into?

LARRY MERLO: Well, Susie, I'm saying it's different. And, I mean, you think about pharmacy operates mail-order. We have mail-order pharmacies today. Some of our competitors do the same thing. If you had the opportunity to visit one of those mail facilities, they would look more like a manufacturing facility than they would a distribution center. So I use that as a contrast in terms of, you know, how some of the elements are different. But listen, if Amazon were to enter that space, I'm sure that as an industry, the industry would respond. There are a lot of things that we do today that we see as unique and there's more that we can do. And, you know, I think one of the opportunities that we have is, you know, you think about the fact that we have almost 10,000 pharmacies across the country, we operate a mail-order pharmacy, you know, today, about 80% of the U.S. population lives within three or four miles of a CVS. So you think about the opportunities that we have that, as a consumer, you can say, well, wait a minute, I want to pick my prescription up at CVS or I want to have it mailed to my home or, you know, what would it mean if we said we could deliver it to your home, or deliver it to your office. So we have all of those capabilities today that, I think, would allow us to compete in a world that is evolving.

SUSIE GHARIB: I'm sure that Amazon would have some kind of fantastic delivery thing that we haven't thought of. But it's not so much the delivery part of it, from the people who are

familiar with what Amazon has been talking about internally, is that they might want to eliminate the middleman and that means the PBMs, that means companies like CVS, and then pass along those savings to consumers. It's possible they're going to be talking about ways that consumers can comparison-shop to find out what different prices you can get for a certain drug. So, if that does happen, let's just say hypothetically, if that were to happen, what is the CVS strategy?

LARRY MERLO: Yes, and Susie, I am confident that as our strategy continues to evolve that we will be an effective competitor in the marketplace. You know there is a role, we talked a little bit about the role of the PBMs in terms of driving down the price of pharmaceuticals. And listen, there's a lot that can be done. I know we have some of our clients here in the room that, you know, we're proud of the fact that if you look, in 2016, our clients' drug spend year over year increased about 3%. Left un-managed, you know, the drug trend for 2016 was almost 12%. So, you know, the role of the PBM is critically important. I think what makes, you know, CVS Health unique is the role of the PBM combined with our capabilities, with our retail pharmacies and our specialty pharmacy business and some of the assets and attributes that, again, Barbara touched on, you know, connecting the dots across those different assets allow us to provide differentiation in the market that is unique and certainly goes a long way to hit on those three variables of access, quality, and cost.

SUSIE GHARIB: Well, on that subject of access, quality, and cost, let's talk a little bit about the Affordable Care Act. What do you think of the new proposals and executive orders that President

Trump just signed? What do you think about them?

LARRY MERLO: Yes, you know, Susie, I think that if we start with what is it that everybody agrees with, okay? I think that it's safe to say that I think everybody believes that, you know, we should be able to provide affordable access to health care for all Americans. I think the debate, okay, and the ongoing debate has been exactly how do we get there. And I think that debate is going to continue. I think, I am optimistic that we'll eventually find the right answer. I think we're doing what we can, okay, in terms of jumping into those discussions, in terms of talking about opportunities that we see that, you know, we think are not being leveraged or capitalized. And one of them we touched on earlier is how do we think about where the care is administered as a variable of care. And, you know, I would sit here today and say we do not put enough focus in terms of valuing the opportunities that we have, not to compromise the quality of care, but to provide care in a lower-cost care setting that will ultimately reduce the cost of care.

SUSIE GHARIB: But specifically to what President Trump, these early new actions that he's been doing, he says that his proposals will get low prices for great care. And the experts are saying it'll actually make care more expensive, especially for people who are really sick. So, what are your thoughts on that? What do you think of the direction he's going in?

LARRY MERLO: Well, I don't believe that we can, that we can piecemeal, okay, some of the dynamics that exist today, because, you know, every action has an opposite action as you go

down the different components or dynamics associated with health care. So, I think it becomes very difficult, okay, to look at one aspect without also talking about, okay, what is the unintended consequence associated with an action here that, you know, and that's why we talk a lot about whether it's, you know, back to site of care, the role that pharmacy can play in reducing the cost of care, that $300 billion that I talked about. And there's not enough focus, okay, that if you do this, okay, then, you know, maybe there's an opportunity to work in this particular area and that, I think that's a little bit of what has everyone a little frustrated.

SUSIE GHARIB: Oh, it is frustrating. It's a very complicated issue. As you said, you touch one thing and then you have something somewhere else. Do you think it would be, we'd be better off, Americans would be better off – keep Obamacare as is with its flaws – would you favor that?

LARRY MERLO: Susie, I think that there is, if you go back to those three variables around access, quality of care, I think that most would agree that, you know, the Affordable Care Act, no question that it improved access. We saw more Americans have access to care, largely through Medicaid expansion. There is evidence out there that it improved elements of quality if you consider preventive care as a measure of quality. I think what most would also agree with, that it did very little, you know, around cost. And it's, I would sit here and say that our actions should be focused on how do we solve the cost equation component of those three variables?

SUSIE GHARIB: Do you have an answer to that question?

LARRY MERLO: I have many answers to that question.

SUSIE GHARIB: What would you, as the CEO of CVS, this very powerful health care company, what would you like to see?

LARRY MERLO: What I would like to see is, you know, we touched how does site of care play a role in overall health care? And one of the arguments that you get is you have fragmented care. I don't think that that, I don't think that has to be the case because we can create a connective care experience through the electronic health record. I think that's one element. I think pharmacy has to be recognized in a bigger way for the role that it provides. We talked about the fact that the pharmacist should be able to practice to the top of their license. Today, pharmacists work with their hands too much. They're doing administrative tasks. You know we need to get them to use and work with their minds. The same thing can be said of nurse practitioners. I think, you know, they continue to be the most accessible health care professional that exists across the supply chain, but yet we're not utilizing their talents in a wholesome way. So, you know, certainly it can start there. And there, if you start there, there are many, many benefits that that can derive.

SUSIE GHARIB: All right, let's open it up to questions. Yes, over here. Let's get a microphone

so everybody can hear your question.

QUESTION: Thanks. I was listening to you talk about the opioid crisis and the rising dynamics around that, and I wondered if you would make a comment on whether you see there being a future in medical marijuana? And how that might help in long-term care and how a company like CVS, who operates in the mainstream of health care would feel about that?

LARRY MERLO: Yes, it's a great question. And, you know, I think one of the questions out there is, is marijuana a gateway drug? And if you talk to the clinicians, there's evidence on both sides of the equation. Some say it is, and some say it's not. I do believe that is a concern for society, okay, that to the extent that it is a gateway drug, then we've got an additional challenge that we have not seen that dynamic evolve at this point in time. If your question is do you see us dispensing medical marijuana, I don't see that, certainly in the near future.

SUSIE GHARIB: Why not?

LARRY MERLO: Today, pharmacies are not licensed, okay, to dispense medical marijuana. And I don't believe that there is enough evidence that would constitute that as part of our practice today. And, Susie, if you turned around and said tell me more about what you're talking about, there's no standard in terms of the concentration of, you know, the active ingredient in marijuana, THC. So it starts there.

SUSIE GHARIB: Okay, more questions. In the back there...

QUESTIONS: Thank you very much. You were talking about the future of health care and it sounds like the industry would have to leverage big data analytics more and expand the access to information between doctors and pharmacies and health care professionals. And I think the challenge that the industry would need to balance is to make highly sensitive information wider available. So, as a cybersecurity professional, I'm wondering what is your vision for securing this highly sensitive information and preventing insider threats?

LARRY MERLO: Yes, there's no question that cybersecurity is certainly a new dynamic and, you know, one that we spend a tremendous amount of time on, you know, in our company and in our boardroom. And it's, you know, it's not a once in a while focus. It's become an everyday focus within, not just our IT shop, but the entire organization. Because, listen, you know, we've got 243,000 colleagues across CVS Health and cybersecurity is not just an IT function. We all own it in terms of what we do to, whether it's protect our passwords, and some of the things that occur today with phishing and whatnot. So, you know, we will continue to have an ongoing focus. I think one of the debates that's our there is, as we move forward with some of these more advanced programs, do they become more opt-in programs for the patient, okay, versus what exists today, and those are discussions that we are having. I think that the opportunity to provide that coordinated care and for the patient to see the benefits in that, I do believe that that becomes

our responsibility. And patients seeing that benefit, I think that it's something that they will want to have as part of their portfolio or their regimen.

SUSIE GHARIB: Okay. I saw a couple other hands that came up. Sir...

QUESTION: Thank you. And thank you also, I applaud your decision in removing tobacco products, so thank you again for that. A question around, you mentioned compliance as being certainly an issue and the EMRs being an opportunity in connection with the physician offices. What other technologies do you see coming down the pike that could be helpful in ensuring better compliance to taking medication?

LARRY MERLO: Yes, that's a great question. And, you know, I mentioned the investments that are out there in new devices. Just as one example, we are in the process of rolling out a program that, you know, for diabetics, where we actually have a connected glucometer that the patient receives. And we're actually able to measure their blood glucose levels in real time via the Cloud. So, you know, we have clinicians that have the responsibility for that monitoring and when the bells go off, if you will, then we get in touch with the patient and/or caregiver in terms of intervening at an appropriate point where without that, okay, the intervention may have occurred in the ER when perhaps other complications or consequences were setting in. So, I use that as an example of kind of the, where the world is headed. And I think there will be more opportunities like that as we go forward.

QUESTION: CVS Health has been at the forefront of the issue of the gap between payment of its highest officials and its ordinary workers. What, if anything, have you done about that? And what are some of your views?

LARRY MERLO: Yes, I think that's going to be a question and a debate that will rise as we comply with the reporting standards in next year's proxy season. But, you know, listen, I can assure you that our board of directors, that's something that we have a lot of discussion and it gets reviewed on an annual basis. And not just the executive officers, but our executives broadly, our board has a pay-for-performance objective. And, you know, the compensation is reflected in the performance of the company. And there's absolute alignment in terms of the goals, the performance, and the ultimate pay. As it relates to our workers', our colleagues across the company, we have a very dynamic evaluation process that ensures that our employees, whether we're talking about our nurse practitioners, our pharmacists, our managers, have competitive pay practices and that includes not just the base pays, if you will, but the benefits that are associated by being a colleague, okay, as part of CVS Health. So, you know, I think in summary, it's something that we spend the appropriate amount of time evaluating on a regular basis. And we're very comfortable in terms of the standards with which we manage the business by.

SUSIE GHARIB: I think we have time for a few more questions. The gentleman over there...

QUESTION: Hi. Thank you very much for the presentation and discussion. One of the cornerstones of CVS Health, I would think, is the pharmacists themselves, whether you're talking about the competition with Amazon, interacting with doctors, and more importantly, the consumers when they go into see CVS. Everything that you're talking about, whether it's TV or whatever, is being seen firsthand in terms of their interaction with the pharmacist. What does CVS do to ensure that once a pharmacist becomes part of the CVS family, that they're really the best of breed, you know, whether it's the educational programs they're getting, whether it's the ongoing courses they have to take or whatever, to ensure that that step out there, that face-to-face with the patient or caregiver is really the best in the industry?

LARRY MERLO: That's a great question. And I mean, as you might expect, we have a variety of training and education programs that exist and oftentimes get updated or prioritized, okay, based on what is evolving or what's new or, quite frankly, what we're innovating and rolling out as a company. I think one of the other things that we're very pleased with is that we have, it really starts when these pharmacists are not pharmacists yet. They're in pharmacy school. And we have a very robust intern program where we're looking for the best and brightest when they're in their second year, third year of pharmacy school. And it gives us an opportunity to see them and it gives them an opportunity to see us and really understand what it will be like as a pharmacist for CVS. And so at any given point in time, we may have as many as 2,000 interns that are in various years of education at pharmacy school. We're very proud of the fact that as we see them and they see us, more than 80% of those interns that we make job offers to, when they

finish pharmacy school, come on and become one of our colleagues. So, to me, that is kind of one of the, you know, the best testaments, because we know one another as they're beginning their pharmacy career.

SUSIE GHARIB: More questions from the audience? Do we have time for one more, Barbara? Oh, here's one, sir...you get the last word.

QUESTION: The last word...thank you, Larry, for your presentation. One of the biggest problems or challenges for payers in providing a prescription drug benefit are specialty drugs – 1 ½ to 2% of all the prescriptions filled account for 40 to 50% of the drugs. Specialty drugs haven't had the advantage that, or the opportunity that the brand-generic marketplace has had and biosimilars are starting to develop. You pointed out that there's several hundred in the approval process with the FDA. Concerns that payers have is that the biosimilars will not have the same difference between the brand and the generic that we've experienced when you look at a regular specialty drug versus a biosimilar. Do you have a sense on that? And also, what would CVS's strategy, CVS Health's strategy be to try to improve that situation on price? Because pricing is such a significant component of the overall cost of a prescription drug benefit.

LARRY MERLO: Yes, Angelo, it's a great question and maybe I'll just, I'll quickly share, you know, when the Hep C drug entered the market, that was, I'm going to say three years ago, there was sticker shock for everyone. There was one product. It was a cure. And it was a 10 to 12-

week regimen at a cost of $90,000. Within a matter of, I think, it was six to eight months, a second product entered the market followed by a third product. And today, as you look at the cost of the Hep C products versus the cost in Europe, it's actually less in the U.S. again because of the role of PBMs, okay, than what those drugs cost in Europe, and it's around $40,000. Now, I'm not sitting here suggesting for a minute that $40,000 is inexpensive. But, you know, we saw the cost of that therapy, you know, cut more than half. And the reason around that was competition, a lot of PBMs, you know, those products – while not chemically equivalent, okay, were therapeutically equivalent in terms of its outcome. So PBMs were able to sit and talk about the fact that we're only going to put one of those products in the formulary and we're not compromising effectiveness. We've made that determination that they're clinically effective, equally effective. So now it's about cost. So, you know, we're spending a lot of time in D.C. educating the policymakers in terms of, because, you know, Susie, I'm surprised you didn't ask about what about the government doing price negotiations? We would sit here and say, you know, the government should focus on increasing competition within these therapeutic classes to let us do what we just described. That will bring down the cost. Okay, so, Angelo, to the comment about, we've got to get biosimilars to market faster than we're doing. Europe has probably four times the number of biosimilars than what we have here in the U.S. And the biosimilars will not be priced like generics, but they will introduce therapeutic competition within that class of products that will allow us to do the same thing that I just articulated that we saw happen in the Hep C category.

SUSIE GHARIB: Thank you so much for answering all of my questions and to our audience.

LARRY MERLO: Thanks everybody. (Applause)

BARBARA VAN ALLEN: Many thanks again, Larry, for joining us this morning, and Susie, for a great interview. I want to remind everyone that we have an exciting lineup next week, starting with a breakfast with Congressman Richard Neal. He's ranking Democrat on the House Ways and Means Committee. He's going to talk about tax reform. Then we have at Bloomberg on the 24th our first class of Fellows here at the Club are going to face off in two debates – one on artificial intelligence and another on blockchain. So that should be pretty exciting. And then the third next week, on the 25th, we have with us the Secretary of Commerce, Wilbur Ross, so we hope you'll join us for that as well. So we hope to see you at those upcoming events, and thank you for joining us. Have a great day. (Applause)