Company Name: Aetna Inc. (AET)
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<<Unidentified Analyst>>

It is now my pleasure to introduce, I think, one of the top CEOs in America today, who took over about October of 2010 from the legendary Ron Williams, and that is Mark Bertolini from Aetna. Since that time, I think from my calculations, more than a fivefold increase in market cap during that time, about 5.5 times, and also kind of an embrace of a new capitalism approach, where Mark has spoken out on critical relevant issues to his company. Apparently, there are a few of those in the world of health care these days.

In addition, he raised the wages of the lowest-paid employees at Aetna, something that some people were, wow, how can you do that? And has worked out extraordinarily well for the company, for those employees and saved money. And also has evolved his shareholder base in a very powerful way to have a shareholder base that is aligned with the strategy of the organization and the business.

So let me introduce Mark Bertolini, CEO of Aetna.

<<Mark T. Bertolini, Chairman and Chief Executive Officer>>

Thank you, Daryl.

<<Unidentified Analyst>>

Check out his shoes.

<<Mark T. Bertolini, Chairman and Chief Executive Officer>>

Sorry about the shoes. I'm a bicyclist. I spend a lot of time on my bicycle. Every morning, I do 15 to 20 miles. But this weekend, I went hiking in Colorado in the mountains, boulder hiking. And my feet, I learned about all the axillary muscles you have in your feet that are now very painful and swollen. And so my regular shoes don't fit. But I think it's sort of cool anyway.

So what I want to talk to you about is what we think in Aetna about our investment in our people and in social responsibility as a company. And so I'll take you through some slides, but I'm more interested in your questions and talking a little bit about more in depth.

We started our journey actually in 2007. When I came to work – and as a result of – I'm a spinal cord injury survivor, so I have a very damaged left arm, et cetera, and a broken neck and a spinal cord injury. And I was using yoga and meditation to manage my pain

because opiates weren't doing it for me. I tried all seven, all seven at once, and it didn't seem to matter. And so I went into yoga and meditation, and I carry around my own acupuncture needles. I do my own acupuncture.

And so I came to work one day, I said, we should do yoga and meditation for the whole company. And the management team looked at me, oh, my god. Here we go. And I said, well, it's really good for us. And so they sent the Chief Medical Officer to talk to me about the fact that I was engaging in voodoo medicine. And I said, well, Lonny; Lonny Reisman was his name, a really great entrepreneur in health. And I said, Lonny, what would it take for you to believe? And so we did a double-blind study, of course, with amazing results, which I'll talk about in a minute, but that began a journey for us of learning and investment in our employees.

That when you look at our stock price performance, $29.85 a share in November of 2010 to $162 a share as of yesterday, it's back about $5 a share because everybody's reacting to Graham-Cassidy today. But it's all right, it's a good time to buy. 63% of that increase is related to our price earnings multiple, not our earnings per share. And I believe as a basic sentiment that the price earnings multiple is The Street's evaluation of whether or not what we're doing has strong business fundamentals, is sustainable and will keep customers over time. It's that investment in our employees that has made a big difference.

So we're talking about building a healthy – well, here's the disclaimer. Okay, done? All right. We'll move on. So in 2002, we were losing $1 million a day as a company. And we – the first thing we did is this; we created a set of values for the organization because what we wanted every employee to know is what to do when a customer had a problem, if there wasn't a suit around to give them an answer.

And so these values have endured as a company; integrity, doing the right thing for the right reason; caring, we listen to and respect our customers and each other; inspiration, we inspire each other; and excellence, we always focus on the highest quality. And these set of values are around the people we serve, and these values are measured every year in our executive compensation. 10% of it is related to whether or not the company and the employees believe we live these values every day. So it's a very important aspect of who we are.

Now helping people live healthier lives causes us to redefine health, and I'll use redefine loosely for a moment. A healthy individual's productive. A productive individual is socially, physically, spiritually and economically viable. And viable people are happy. Now we can't say that today en masse across the country because what we've built is really on the far left-hand side, our insurance products that are a warranty system. You get broke. Here's your card. And when you're broke, come, we'll fix you.

And quite frankly, that's not how people think about their health. When you think about your own health, as I do about mine, it's what my health prevents me to do in life that I really want to do. It's not the ideal front cover of Men's Fitness Magazine, which is about 3% of the population and usually airbrushed. It's really what does my health do in getting

in the way of the life I want to lead. That's what people want. A warranty card system doesn't do that. And yet we spend $3.2 trillion as a nation on a warranty system.

So we really have to move beyond that to empowering our members, which means we have to understand their own personal reason. I'll give you just an example. If I'm a diabetic with pedal neuropathy, and I can't walk anymore, we say, you know what? If we get your diabetes under control, you can run the 5k next year at the senior center run. And you've never run an inch, you don't care. But if you say, you know what? Did you take your granddaughter for a walk every day? Did you like to go to the park? Did you walk to the senior center to get – play cards on Wednesdays? And if we get your feet fixed, you can do that again. Now you've got my interest because that's the life I want versus the life you think I should lead.

So we – now here's our numbers. So we serve 22.1 million medical members, 13.6 million dental members, 14.8 million PBM medical services. We serve 54.5 million people around the world. And last year, we paid for health care in every country of the world, around the globe. We have about 1.15 million healthcare professionals, thousands of doctors and over 5,700 hospitals. But more importantly, we're in an environment now, today's a perfect example, our stock's down $6.34 because Graham-Cassidy might pass, which will affect Medicaid reimbursement, which will take seven years, and I have yet to meet an investor who stuck with us for seven years anyway. So why does it matter that it's going to be seven years from now? That Medicaid funding is going to be impacted on literally what is 10% of our business. But having said that, they're reacting to what is happening in Washington today.

We're shifting to value-based models. So we're partnering with hospital systems across the country, Allina Health care, Texas Health Resources, Banner Health Care, Inova. And we're building pseudo-companies, which are joint ventures between Aetna and those systems, to share risk and align our economic interests. So if we win, if they win, the customer should win because we're focused on improving the health of those members to drive down costs, and they share in the underwriting margin.

In Aetna, for every 50 basis points we change health care costs, it's $480 million of underwriting margin that can either be brought to the marketplace in pricing or brought back to invest in the business or to our shareholders; $480 million. So the big number for me is, everybody, how many basis points have we brought down health care costs? And what more and where can we find the next 50 basis points? And it's all about increased consumerism.

Personalized health, the description I gave you earlier of understanding what health is doing to get in the way of the life you want to lead, is all above consumerism. And the only way we're going to make it work is when our interests are aligned with the consumer as well, where when we invest in their journey to eliminate the barriers that get in the way of their life, they win and we win because they're healthier. They're living the life they want to lead.

So here's the old model of conventional managed care. We fight with the hospitals to get cheaper prices. We then underwrite that risk based on an underwriting model where formulas – we're a 165-year-old company. I'm the 14th Chairman of a 165-year-old company. And our formulas are 165 years old. And I'd be willing to bet you that there are indeed actuaries in our company that are 165 years old or older because they had to go to actuarial school first. And then we manage utilization. We get in the way, and this is all driven around a warranty system. It doesn't work.

So – and here's why. The United States, as part of the first-world countries around the world, spends 64% of its dollars on health care and 36% of its dollars on social programs when you put it together. So in the OECD nations, we are 11th in total health care spending and social spending; 11th. There are companies that spend more. We are the only country that spends more than 40% on health. Everybody else spends 40% on health or less and more than 60% on social programs. So we've got it upside down.

In this system, we are 34th out of 34 – it's always good to be in a notable place for the value of care delivered, where 50% of our conditions are chronic, driving almost $2.25 trillion worth of health care costs out of the $3.2 trillion; where we waste 30%, this is an IOM, Institute of Medicine, number from doctors who evaluate that we waste 30% of our spending in health care; and where in real household dollars, grow – income growth has gone down 0.5%, and health care costs have gone up 5 – 53%, where now consumers are spending almost 43% of their dollars on health care. It's the single largest line item in the household budget today, more than mortgage, more than taxes, more than rent, more than anything else.

So when you look at that kind of spend in a 34th out of 34, spending $3.2 trillion, of which a third is wasted, we sort of have a problem. And what I tell our people on the team is, if we have an opportunity to fix this, the next $10 trillion worth of debt will be comprised 75% of Medicare and Medicaid. If we fix that problem, we save the nation's economy. That's as simple as it gets.

Here's an even more startling chart. Of all the dollars we spend, here's the impact on life expectancy. 10% is related to clinical care; that $3.2 trillion we spend, 10%. 30% is based on your genetics, and the remaining 60% is on where you live, your social determinants and your lifestyle. So your ZIP code matters more than your genetic code when it comes to how long you're going to live. And so we have ZIP codes in Baltimore; in the Bronx; in Detroit, my hometown; in Chicago; there's my Midwest accent, it just came up; where we have life expectancy of 15 to 20 years less than the ZIP code next door because of where you were born.

And so when you think about how we're spending our money, 60% on healthcare and 40% on social, given the economic downturn in 2008 and the disappearance of the middle-class, is it a concern for anybody at all that we're underspending on these social determinants, which by the way now are cheaper than going to an emergency room? And if you wonder why we have an opioid crisis in this country, where 80% of all the opioids produced in the world are consumed by Americans, enough to keep us all stoned for six

weeks if we were to take them, it's because of this. The safety net's eroded. Maslow's hierarchy of needs, high school, simple lesson. And until we invest in those, we aren't going to make a difference.

So we, as a company, are. And we believe the only way to fix this is to begin to move away from the focus of managed care and limited disease management on individual behavior by shaking our finger at people and saying, you shouldn't smoke, and you need to walk more, and don't eat those fats. We should really start to think about how do we invest in these social and environmental factors that make a difference. So we're doing this now in Florida. We've been doing it for 10 years in Arizona, where we go to people's homes, assess their environment and get them the services they need; an Uber ride for socialization to the senior center on Wednesday, food for the refrigerator, heating assistance.

We had a lady in Camden, New Jersey, 75 years old, asthmatic, 405 ER visits in one year, which is more than one a day, $2.7 million. She had Angora rugs or sweaters and angora blankets in her home because she kept the thermostat down. She's allergic to Angora. That's why you've got to get in the home. You have to start taking care of these social and environmental factors because they've been uncovered by our economic decline in a meaningful way, where middle-class families can no longer afford the things they need.

And we need to move to this definition, which was actually devised by the World Health Organization almost 70 years ago, that the definition of health is the complete physical, mental and social well-being and not merely the absence of a disease. But our whole system is built on that last prepositional phrase.

So we are now going into communities. Aetna has planted 5,539 new urban farm beds across America over the last two years to eliminate food deserts. We are now developing a next generation of digital tools, the Apple watch partnership that we announced recently, the kind of platforms where they will become tools to support people's journey, not a cool thing for people to use. And they'll be connected.

My daughter wanted this sweater from Macy's, and she told me it was a V-neck cashmere sweater. So she sent me over to get it. And I took out my Android phone, and I scanned it. And Google Shopper came up and said, here's where else you can get it. Here's who makes it, and it showed me where the cheapest one was. And so I clicked on that one. And the address came up and the phone number from Google Maps, and I called ahead and reserved two sweaters. And I walked over to the store and I got one for Lauren and one for the team. And I brought it to work and said, why can't we do this in health care? Why do we have to have different passwords? Why do we have to have different apps? Why can't it be all linked together?

And so as we look at this, then it brings local care teams. So think of a world where the sicker you are, the more we bring to your home and the more high touch we provide. And the more well you are, the more retail it looks like, think CVS or Walgreens

reformulated. That's more high-tech, and that we titrate the two together over time to build the best model for you. That's called personalized care with local care teams.

So when we think about value creation, there's all these things that you all spend time thinking about, but what we thought about was human capital and our journey with our employees. So I travel the country and around the world. I travel 200 days a year, and I spend a lot of time with our employees. So I go to their desk. I shake their hand in their cubicle, ask them how it's going, and I kept hearing about how hard life was for them.

And also, in our mindfulness and yoga program that we provided, my partner, Mari, she was teaching the first class because she's an evolved yogi. She's farther along the path than I will be – she will run out of lives before I do. And she was telling me about how hard it was when she was reading the journals back from the class. And I was reading these journals about how difficult life was for these folks.

So I said to our HR folks, you need to tell me who these people are, how many of them are, what is their life like, how do they earn a living, how do they take care of their kids And what we found is that more than 80% were women. Most of them are single mothers, that we had people on food stamps and we had kids on Medicaid. And here we are, stock price going up, earnings going up, P/E going up. We're on a ride, and these people were being left behind.

Now that is probably an example amongst every company in America and every economy around the country of the people left behind. So I said to the team, what do we need to do? And after fighting with my HR department about raises, I finally said, let's take them from $12 to $16. Oh my God, it's going to cost us a lot of money. And let's wipe out the health care cost for people under 300% of the federal poverty level, because the more we raise their salaries, the less eligible they become for support, and get them engaged in our disease management programs and in our wellness programs as a cost of them getting their health care cost wiped out.

It was about $27 million for us in the first year. It impacted about 5,700 employees, all who received on average a 22% increase in personal disposable income, some of them as much as 45%. But that wasn't the end. We raised our Tuition Assistance program. We now pay back student loans up to $10,000 for our employees. We pay them to sleep 7.5 hours a night for 20 nights in a row for $300. Try it. How many people here sleep 7.5 hours a night? Not too many. And then if you do it for 20 nights in a row, let me tell you, you will want to sleep for 7.5 hours a night for the rest of your life. That's what I do.

Now when somebody said, we can't make the spreadsheet work. So spreadsheets have been a bane upon American business. We have destroyed Japan. We're about to destroy China and the Middle East because they send all of their MBA students over to the United States to learn about spreadsheets and PowerPoints, because if we put it on a spreadsheet and the number in the cell is the number, then, oh, my God, it's true. And then we put it on a PowerPoint. We wrote it down. It's got to be true. And the great thing about spreadsheets is you can play with all the variables until you get the answer you

want. When I first started with my deck rainbow and VisiCalc, if you didn't recalc every time you changed a number, it was wrong. Well, that's something you didn't hear. Remember that one.

So what we had to do is we had to change the conversation we took from what does the spreadsheet tell us to a conversation that said, what do we need to believe in both the hard and soft benefits that allow us as an organization and a management team to take the risks associated with this investment? That was the bet. And when you array all the benefits, hard and soft, the soft ones, even though you probability-adjusted at a much lower rate, when you add them up, they're almost as big as the hard benefits. But we always discount those by saying, it's too hard. Just leave them off. The spreadsheet never works.

So changing the conversation from what does the spreadsheet tell us, to one of – and then how do we manage the variance when we're wrong, because every spreadsheet's wrong from the moment you put it together, we had to go to the what-does-this-believe phenomenon. So we engaged our front-line employees. We had great results. We looked at some of these as the benefits. We introduced wellness programs, as I discussed earlier, and we have created great shareholder value. Our employee engagement scores are up 1,400 basis points. That has to matter, I think.

Our stock price when we increased the wages was $72. We're more than double since then. That was 2015 I was with 250 million of our 300 million shares the day we announced it at another person's conference in San Francisco that will go unnamed in early January, and I didn't get one question from our shareholders about why I did it. I only got, great idea. It's a good thing for your people.

So as we think about how we spend our money, we have our dividend. 1.1% is based off of current stock price and the fact that we just raised our dividend to $2 a year. So we just took it up a bit. We do share repurchase as the last result. So we do dividend yield. We do organic growth, and organic growth is our highest opportunity. For every dollar of premium we write, we put up $0.15 as risk-based reserves, which returns us an excess of 30%. So organic growth is a real winner.

Then we talked about how do we do internal growth; how do we generate more internal growth; how do we grow that top line and generate more of that return on invested capital in our risk-based capital. We then look at targeted M&A against share repurchases. So when we do our plans, we put all the rest into share repurchase, it's about $1.3 billion, and we measure the return on that as the threshold over which our M&A has to exceed. So we're not planning M&A. We're ready for it, and we're using share repurchase as proxy. And we think we can do well by doing good. 14% increase in employee engagement, 12.3% three-year adjusted EPS CAGR, and you can see we've beat the S&P 500 pretty handily all over the last three years. And it's up 5.5 times since we started.

So our new ad is about, you don't join us, we join you. It's your journey. We want to understand what your journey is, and we want to engage you in a project. And if we can engage you in that project, we can go along in a very fruitful way to help you. And that

way, we're no longer the people that screw up your claims. And this is me because I ride motorcycles as well, but I've graduated from that one. I've had that helmet though.

So with that, I'll take any questions you may have.

Q&A

<Q>: Thank you so much. It was great. I never thought of a spreadsheet as WMD, but that's something to learn here.

<A – Mark T. Bertolini>: It's true.

<Q>: So a question came in through the app. And this has been – for people that don't know, this is being live streamed through Wall Street webcasting. So all these slides and all this information is downloadable. It's being watched by hundreds, if not thousands of people. It's also – all this is on the Bloomberg terminal, so we're very pleased with that. But my question is, how does – the question from Hermes, which is a leading authority in devising pension funds in the UK, how does the U.S. solve the problem of widespread opiate addiction? And what can Aetna do to help specifically?

<A – Mark T. Bertolini>: So we're already doing it. So a few statistics. The highest number of prescribers of opioids in the country are dentists. And they offer opioids after any oral surgery, and they usually offer 45 pills when you only need five, if that, at all. And so what happens is this gets into the illicit drug trade because it ends up on the shelf somewhere, because you don't take it all. We also have 1,000 doctors that prescribe regularly large amounts of opioids.

So we've all sent them a letter, the dentist and the doctors, and over the next 120 days, because that's what it takes to change things in our health care laws in the country, we will no longer allow more than seven pills for the first prescription. Because we know that if you have more than seven pills, between seven pills and 15 pills of opioids, addiction goes up more than double. So the idea is to get in front of it

Now we still have all that inventory out in the community. And if you watch – well, I'm not intimating that I watch heroin prices, but if you were to watch heroin prices versus opioid availability, the more available opiates are, the lower heroin prices are. And when it becomes scarce, heroin prices go back up. And now heroin is laced with fentanyl. This is one of the leading – to give it a better buzz, because it's one of the leading killers.

So the second thing is we're treating people with medicated-assistance withdrawal for opioids. So we now have nurses. So here's an – in West Palm Beach, pretty cool area, right, high influence. They used to have 30 ambulance rides a day for overdoses – 30 ambulance rides a month for overdoses. This is now 30 a day in West Palm Beach. So what we're doing in West Palm Beach is we're saying to people that come in, if you're willing to begin on medicated-assisted withdrawal, we'll give you your first shot of

suboxone right now. And there's a 90% success rate with withdrawal and maintenance off of opioids when we do it right at the point when somebody's just overdosed.

The third thing we're doing is we're offering Narcan to first responders. Now I used to be a first responder in Detroit, and in the downtown area, Cass Corridor. And when you're a first responder, you carry Narcan. And Narcan is a Lazarus drug. When somebody is totally overdosed and not breathing and everything else and you give them Narcan, it puts them through complete withdrawal all at once, and they literally fly off the gurney. So we're giving them Narcan.

The other thing is we're beginning to talk to hospitals and doctors about what we can do to offer other versions of pain management for individuals. Our goal is by 2020 to reduce the addiction rate by 50% and to reduce the prescription rate by 50% across the United States. So we're launching in the hotspots. We have a map that shows the hotspots across the United States, in some of the most unlikely places you'd imagine, they're not all inter-cities, by the way, as a way of starting to get at this issue in a very meaningful way.

Now I've had questions from investors that say, well, drugs are cheap. Opioids are really cheap. Why not just – if you save money on not having opioids, then what does that matter to us? And my response to that is that when you've got 40% of Midwestern families with somebody addicted to opioids, and 85% of the people in the United States know somebody addicted to opioids in one way, shape or form, we have an economic and social problem that is going to bring us down if we don't resolve it. And it's a loss of hope, a desperation and a loss of hope on the part of the American people because they'd just rather be stoned than figuring out what to do next to make our nation a great nation.

So yes, opioids are cheap. Suboxone's very expensive. Narcan's very expensive. These treatment programs are very expensive, but there's a broader national challenge here that we have to address. It's now bigger for us, as we look at our costs, than diabetes as a pandemic. Okay, next question?

<Q – Lee Fang>: Hi. My name is Lee Fang. I'm a reporter for The Intercept. I have two questions. One, about the democratic side, there seems to be a lot of momentum towards single payer.

<A – Mark T. Bertolini>: Yes.

<Q – Lee Fang>: I wanted to ask if you had any opinion of the Medicare-for-all bill that Bernie Sanders and 15 Senate Democrats proposed last week. And number two, on the Republican side, it looks like there's one last ditch effort to repeal or significantly change the Affordable Care Act, Graham-Cassidy, which you've mentioned earlier, which allow states to issue some waivers, some of the federal mandates. I wanted to get your reaction on that as well.

<A – Mark T. Bertolini>: Sure. So I'm now a little infamous for this conversation, but I'll ask anybody in the room, can you tell me what single-payer is? So what I usually hear

from people are saying, I'm frustrated with the health insurance. I just want single payer. So tell me what it is. Let's talk about it. Anybody? Bueller?

<Q>: [Inaudible]

<A – Mark T. Bertolini>: Health care provision? No. I mean, are we talking about socializing all the hospitals and doctors, everybody's going to work for the government? Call it the VA, right? Name a country that has single-payer.

<Q>: [Inaudible]

<A – Mark T. Bertolini>: No. It's a government-run health care system. They're not the single-payer, they're the single everything. So the laws that people are talking about are both about taking insurance and having the government pay for all the insurance. It does nothing to fix the underlying cost structure of the slides I showed earlier. And so if we refinance a lousy product, what do we get? A lousy result.

And so what we have to do is we have to fix the underlying issues, and we have to – so we've got financing and investment all confused in health care. I'm from Detroit. You can't go to GMAC to buy a car. GMAC finances cars. Insurance companies finance health care. You can't go to GM to buy a car. If you knock on the door, they can't give you a car. They won't sell you one. You've got to go to a dealership. And you talk about what it is you want out of your automobile. Is it red? Does it have a convertible top? Does have a leather interior? Does it go fast? What kind of wheels does that have? How wide are the tires? And then you decide how much it's going to cost.

So I have four motorcycles and a pickup truck in my garage. They're all clean. They're trickle charges because I travel all the time. They're fully gassed up. So when I get home, I can ride them or drive them. My better half, she has a 2002 Subaru with one headlight. Every fender's dented. God washes it, and it goes to the gas station when it doesn't run. We have two very different ambitions for our automobile or for transportation. People have very different ambitions for health care. Why should we finance and tell you, everybody, here's your health care, through the financing mechanism?

So we've got to fix the underlying system, then we can finance the right thing. And if the government wants to pay for all of it, we pay for all of the medic – the industry pays for all Medicaid and Medicare. The government doesn't cut a check. I have the first check, Medicare check in 1965 to Hartford Hospital, very first government check to Hartford Hospital for Medicare for $571.74. So we run it.

And if they want to provide more people with Medicare, we know how to run that. If they want to provide more people with Medicare, we know how to run that. And we can figure it out, and employers can keep offering coverage if they want. That's what we have today. And if we'd done that with Medicaid expansion, and we'd reduced the eligibility age for Medicare for people who could means-test to support their own Medicare, Medicare for More is what Hillary called it, we would've been in a better place, we'd

have covered more people than we're covering right now, and it would've been cheaper because those systems work.

<Q>: What about the Republican plans?

<A – Mark T. Bertolini>: The Republican plans – so if I were to make bets on – who takes bets on our government law – on our government process or congressional law development? Anybody? They do it over in the UK for Brexit, but they would never touch it here. So I've got no prediction.

<Q>: Next question, please?

<Q – Robert Brown>: Hi. Robert Brown. Mark, first of all, thank you very much for everything you've done to sort of put pressure on many sides of the health care system. You just talked about the way you handled Aetna's response to the opioid crisis, which was essentially to say we're not going to play that game anymore.

<A – Mark T. Bertolini>: Right.

<Q – Robert Brown>: You guys know more, I would suspect, about drug prices, health care prices than anyone, which is to say the insurance industry. Why aren't you putting more pressure on prices? I mean, we've seen drug prices escalate dramatically over the last 10 years.

<A – Mark T. Bertolini>: Right.

<Q – Robert Brown>: What's your role there, either as a business or socially responsibly?

<A – Mark T. Bertolini>: So a couple of things. So in any one market, we have 7% to 8% market share. In some markets, we have 20%, but on average, we have 7% to 8%. Our largest competitor is Blue Cross Blue Shield of Michigan or Blue Cross Blue Shield of Texas or Blue Cross Blue Shield of Illinois. So it's not United or CIGNA or whoever. So when we go in to leverage share, the people who are actually leveraging share are the Blues and getting the lowest prices in that local marketplace. So it's really a local game, not a national game. I wish the DOJ had recognized that, but anyway, we'll move on. And so there's that issue.

On drug pricing, we're now working with the drug companies about outcomes pricing. But I have to tell you, they don't believe they're part of the problem here. They don't. They've got 26% margins. We've got 5%. And so – and the problem, they say, well, these are good drugs. They're worth it. Unfortunately, we can't prove that. My favorite drug right now is opioid-induced constipation drugs. So if you're stoned all the time and you can't go, it will help you go.

Now how about we deal with the stoned part first, right? And so I think our incentives are wrong, and we could do more. I think drug pricing transparency, complete pass-through to the customer and having the lowest drug cost for the therapy provided or the best drug for the therapy provided will end up with the lowest cost of the overall outcome. So when SOVALDI came out, we did not get in the way because hep C is a big issue. We need to deal with it. Liver transplants, death, we get that one. And $89,000 was okay. But there are other drugs that quite frankly don't make a whole lot of sense, and we need to push back on them.

So I think getting all the middlemen in the drug industry out of it, so we can see what the real price is and deal directly with pharma from a consumer standpoint, will make a big difference.

<Q>: Last question. And one more here from the –

<A – Mark T. Bertolini>: From TV Land?

<Q>: From TV Land.

<A – Mark T. Bertolini>: We've one in the back there.

<Q>: We've got one in the back of the room here.

<Q>: Very good.

<Q – Rob Fernandez>: I just have –

<Q>: Name?

<Q – Rob Fernandez>: Rob Fernandez – sorry, Rob Fernandez with Breckinridge Capital Advisors. Just thinking about share repurchases, you said you do about $1 billion a year.

<A – Mark T. Bertolini>: Yes.

<Q – Rob Fernandez>: That you invested – I think it was $78 million in pay raises for employees.

<A – Mark T. Bertolini>: Yes.

<Q – Rob Fernandez>: Just thinking about the balance there. I know share repurchases are very popular, and the Allstate CEO talked about that earlier this morning. Just wondering how you can maybe balance that a little bit more or maybe you do get some pushback from investors if you cut that down.

<A – Mark T. Bertolini>: No, no. I think $1 billion – and here's how I feel about share repurchases. It's when we have nothing else to do. That's valuable, right? So we give it

back to you. We say, you know what? We don't need your money anymore. So here it is, you can have it back. So I think for us, the first is, what can we do internal of the business because of the returns we get, including our employees. We're constantly monitoring that and moving it up. So all these things I talked about, we've added.

So we're probably north of – or near $100 million now in total spend on that. So we continue to make that investment as long as it makes sense from the standpoint of employee loyalty and everything else. We look to invest internally in the business. We look to buy things that we need from the standpoint of capabilities, not for size. And then whatever's left, we give back to our shareholders, okay? Good?

<<Unidentified Analyst>>

With that, thank you, Mark.

<<Mark T. Bertolini, Chairman and Chief Executive Officer>>

Thank you very much.