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July 16, 2018

VIA ELECTRONIC MAIL

The Honorable Commissioner Dave Jones
California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814

Re: The Proposed Acquisition of Aetna Inc. by CVS Health Corporation

Dear Commissioner Jones:

We are writing to provide the additional information requested by the California Department of Insurance ("CDI") in its letter dated July 9, 2018 with respect to the captioned matter. Below are the collective responses of CVS Health Corporation ("CVS") and Aetna Inc. ("Aetna").

Prior Information Requests

1) In testimony, Aetna agreed to provide the additional information from the S-4 prepared by Aetna regarding the savings resulting from the merger. [48:13-18] In testimony, and in the July 3 response letter, three categories of savings are noted:

   a. $750 million by the second full year from "improved case management, optimization of sites of care."

   b. An unspecified amount, three to five years after completion of the merger resulting from "the integration... of assets and creation of new products, services, and innovations."

   c. $2.5 billion per year by the fifth full year due to improved operating efficiency achieved "by simplifying processes and projected administrative and other cost efficiencies."

   What is the estimated savings resulting from (1)(b), above, resulting from "the integration... of assets and creation of new products, services, and innovations"?

RESPONSE: The final S-4 was filed with the SEC on February 9, 2018, and is available at the following link: https://www.sec.gov/Archives/edgar/data/64803/000119312518036987/d482402ds4a.htm.

CVS projected in the S-4 that annual cost savings would be approximately $750 million in the second full year following completion of the merger (which is assumed to be completed in the second half of 2018 for purposes of calculating the estimated synergies), which increase by 5% per year thereafter. *See* page 161 of the S-4 in the second paragraph under the heading "CVS Health Combined Company Projections" and note (3) on page 162 of the S-4. Aetna's projection is that: "[t]he merger is expected to create significant opportunities to increase the combined company's operating efficiency by simplifying processes and projected administrative and other cost synergies, which Aetna believes could be $2.4 billion per year by the fifth full year following completion of the merger, and which Aetna believes will further drive efficiencies and cost savings for consumers and customers."[1] Integration planning remains ongoing and the specific breakdown of dollar amounts regarding integration of assets and creation of new products, services, and innovations is not available.

2) In testimony, Aetna and CVS agreed to provide an estimate of what amount of the $750 million annually will be allocated to premium reduction or decreases in premium increases. [51:22-23, 52:3-5] The July 3 response indicated that the $750 million in annual recurring savings "could be passed on to consumers in the form of lower health premiums." Does CVS commit to allocating at least some portion of those savings to lower health insurance premiums, or to reduction in increases? Does CVS commit to allocating at least some specific percentage of those savings to lower health insurance premiums or reduce increases? If so, what is the percentage?

RESPONSE: Cost savings from this transaction will allow CVS to be even more competitive with its many market rivals, ultimately passing on additional savings to consumers and employers. CVS will pass along cost savings to consumers in two ways. First, as CVS's costs decrease, it will be able to lower premiums or not increase them at the same rate. Second, CVS intends to invest savings from the transaction into improving the quality of services it offers. Thus, these cost savings will improve consumers' experience in ways beyond merely the cost of their premiums. CVS commits to allocating a portion of those savings to lower health insurance premiums or to limit the size of increases in premiums. However, at this time CVS cannot allocate a specific percentage of those savings given that many elements go into determining health insurance premiums, including the costs of prescription drugs, hospital costs, physician group costs, and other items beyond CVS's control. It is therefore impossible at this time to predict the overall cost of premiums and other health care costs in any specific market.

[1] Please note that the prior response and page 102 of the S-4 provided for $2.4 billion and not $2.5 billion as indicated in the question.

3) In testimony, CVS agreed to provide the value of the rebate retained by CVS-Caremark on an annualized basis. [60:2-13] The July 3 response notes that:

   a. CVS Health passes on more than 90 percent of rebates overall to its clients.

   b. CVS Health reduced drug trend for its commercial clients to 0.2 percent in 2017, the lowest level in five years, despite manufacturer list price increases for brand name drugs of near 10 percent.

   c. Core PBM strategies reduce drug trend.

   However, the response provided does not provide the annualized value of the rebate retained by CVS, and as such is non-responsive.

RESPONSE: When asked about the annualized value of rebates, CVS agreed at the hearing to "[r]eview it and give the information we can give you…" [60:2-13]. CVS provided information on rebates in its July 3, 2018 response, but CVS does not disclose publicly the annualized value of the rebates under client contracts that it retains or passes along to its clients. As stated recently, CVS returns approximately 95 percent of discounts and other price concessions including rebates to commercial clients and their members.[2]

Additional Information Requests

1) How will the asserted savings resulting from the proposed merger be allocated between the operations of CVS and Aetna?

RESPONSE: After the closing of the merger, Aetna will become an indirect wholly-owned subsidiary of CVS and a direct wholly-owned subsidiary of CVS Pharmacy, Inc., a Rhode Island corporation, which is a direct wholly-owned subsidiary of CVS. Savings will flow back to the area in which they arose across the enterprise.

2) Will California policyholders ultimately pay for merger-related changes in executive compensation through increased premiums? If not California policyholders, then who will?

RESPONSE: Certain officers of Aetna will receive change in control payments at the closing of the CVS transaction in addition to the merger consideration they receive as a result of owning Aetna common shares. These change in control payments to officers of Aetna that are paid at the closing of the transaction will not be the responsibility or obligation of California health plans or their policyholders. These change in control payments will be paid by Aetna and/or CVS from available funds.

[2] CVS Health Statement on Trump Administration Initiative to Reduce Drug Cost, May 11, 2018, https://cvshealth.com/newsroom/press-releases/cvs-health-statement-trump-administration-initiative-reduce-drug-costs.

3) Will there be any reduction in California employment by Aetna and/or CVS as a result of the merger? If so, please quantify.

RESPONSE: CVS does not expect any material change to overall employee headcount in California as a result of the transaction except in the ordinary course of business or normal attrition. California is a vitally important market for Aetna and CVS. Aetna has 2,600 employees in California and CVS has an estimated 26,900 employees in California.

4) Does CVS have any current plans or has CVS initiated discussions for future acquisitions of insurers or pharmacy benefit managers over the next five years? If so, what are they?

RESPONSE: CVS has no current plans regarding the above.

5) Representatives of CVS previously testified that CVS is "waging a multi-front fight against the opioid epidemic" that includes an effort to reduce dispensing of opioids and implementing a seven-day limitation [DMHC hearing pp.34-40, also CDI hearing 14:20-23]. While recognizing these efforts, the Department notes that Aetna places utilization management restrictions on almost all prescription drugs used to treat opioid use disorder, commonly called MAT (Medication-Assisted Treatment) drugs. Two of the most common and popular opioid reversal drugs, generic injectable naloxone and brand Evzio nasal spray, are treated inconsistently across Aetna's own formularies. Tier placements for these drugs in Aetna formularies range from tier 1 to tier 3. In some instances, the drugs are not covered, and in other instances these drugs are subject to requirements inconsistent with the circumstances of use, such as prior authorization, failure before prescription through step therapy, or quantitative limits. Aetna consistently places MAT drugs on higher tiers and places greater utilization management restrictions on MAT drugs than most other insurers. What will the merged companies do in the future to increasing access for your insureds, through tier placement and revised utilization management requirements, for these life-saving drugs?

RESPONSE: It is Aetna's position that its members should have better access to Medication-Assisted Treatment (MAT). This evidence-based treatment in combination with psychotherapy is the cornerstone of successful treatment of opioid use disorder. One of Aetna's key opioid-related goals is to increase the percentage of its members with opioid use disorder being treated with MAT. Aetna is focused on reducing barriers to accessing MAT and expanding access to Narcan for at-risk patients. To those ends, in Aetna's large and small group fully-insured commercial formularies, Aetna has removed the prior authorization requirement on buprenorphine and related products, including oral Naltrexone. Further, all of these products have been placed on the preventive medicine list, which may reduce a member's cost-share. Aetna also covers generically available MAT at the lowest patient cost tier on the pharmacy benefit. With respect to coverage of Narcan, Aetna has not only removed prior authorization requirements, but is the only national payer to have also waived copayments for fully-insured commercial members once their deductible is met. In addition, Aetna also continues to donate

Narcan and train local communities on its use in a number of regions hardest hit by the opioid crisis.

Furthermore, Aetna also believes that methadone is an important form of MAT. Methadone, when it is provided in a federally-funded methadone clinic and used for addiction recovery, is covered by a medical plan through the behavioral health benefit. While Aetna currently requires prior authorization for methadone at the pharmacy point of sale (as there is no way to know whether a provider has prescribed it for the purpose of pain management or as part of MAT), Aetna will provide approval if the physician verifies that the drug is being used for the purpose of MAT.

As a result of these efforts, Aetna has already seen, and expects to continue to facilitate, a continued increase in the usage of evidence-based treatment by providers for its members. Going forward, the combined entity will continue to evaluate ways to increase access to and the affordability of MAT and other evidenced-based therapy for opioid use disorder.

6) There was testimony that Aetna does not currently have plans to offer, post-merger, a difference in cost-sharing for customers purchasing from non-CVS pharmacies versus those who purchase from CVS pharmacies. [63:15-20] Are there any enforceable provisions in the merger agreements, or other understanding, that would prohibit such a practice being implemented in the future?

RESPONSE: Aetna plan members will continue to be able to fill prescriptions at non-CVS pharmacies, and CVS does not currently have plans post-merger to offer cost-sharing differences to customers purchasing from non-CVS pharmacies. There are no provisions in the merger agreements on this issue. However, the combined company will continue to have strong incentives to remain competitive in the design of its benefit plans and pharmacy networks post-merger. In addition, Aetna files its pharmacy networks with both CDI and the California Department of Managed Health Care for review and approval.

7) There was testimony that Aetna does not currently have plans to treat CVS and non-CVS pharmacies differently in terms of network development post-merger [63:24-64:4]. Are there any enforceable provisions in the merger agreements, or other understanding, that would prohibit such a practice being implemented in the future?

RESPONSE: Aetna plan members will continue to be able to fill prescriptions at non-CVS pharmacies. Similarly, CVS will continue to fill prescriptions for non-Aetna patients. Customers expect Aetna to provide access to a diverse network of health care professionals and pharmacies. There are no provisions in the merger agreements on this issue. However, the combined company will continue to have strong incentives to remain competitive in the design of its benefit plans and pharmacy networks post-merger. In addition, changes to benefit plans and pharmacy networks must comply with California regulations and requirements.

8) Similarly, Aetna testified that it does not currently have plans to steer persons covered by Aetna to the Minute Clinics in CVS pharmacies. [64:3-14] Are there any enforceable provisions in the merger agreements, or other understanding, that would prohibit such a practice being implemented in the future?

RESPONSE: Aetna plan members will continue to be able to see nurses and primary care physicians at non-CVS facilities. There are no provisions in the merger agreement on this issue. However, the combined company will continue to have strong incentives to remain competitive in the design of its benefit plans and pharmacy networks post-merger. In addition, changes to benefit plans and provider networks must comply with California regulations and requirements.

9) What PBM services does Aetna currently self-provide and for what PBM services does Aetna contract with CVS or other PBMs?

RESPONSE: For Aetna's insured business in California, since 2011, CVS Caremark ("Caremark") has provided several core PBM services to Aetna. Aetna primarily handles customer-facing services, including sales and marketing and pricing, as well as front-end mail-order and specialty pharmacy services for most commercial and Medicare clients. Caremark handles front-end mail-order and specialty pharmacy services for Medicaid and a limited number of commercial clients.

Caremark handles several aspects of third-party negotiations for Aetna. Caremark contracts with drug manufacturers for rebates for Medicare, Medicaid, and a portion of Aetna's commercial clients, while Aetna handles rebate contracting for most of its commercial clients. Caremark develops Aetna's formulary for Medicare and Medicaid, but not commercial. Caremark handles network pharmacy contracting for commercial, Medicaid, and Medicare wrap networks, while Aetna handles such contracting for the rest of Medicare.

Caremark handles Aetna's mail-order and specialty dispensing and fulfillment, with the exception of a small number of restricted-distribution drugs. Caremark also handles all claims processing and rebate administration services for Aetna.

Aetna is responsible for most clinical services, but outsources to Caremark services such as prior authorization, step therapy adherence programs, and drug interaction management.

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We trust that this letter is responsive to the information requested in CDI's July 9, 2018 letter. We thank you for your consideration of this matter.

Sincerely,

LOCKE LORD LLP

Steven T. Whitmer