

October 26, 2018

VIA CERTIFIED MAIL  
RETURN RECEIPT REQUESTED

Tim Farber, Esquire  
Locke Lord LLP  
111 South Wacker Drive  
Chicago, IL 60606

Re: Form A Statement Regarding the Acquisition of Control of  
Aetna Health Insurance Company, Aetna Better Health Inc.,  
Aetna Health Inc., HealthAssurance Pennsylvania, Inc., and  
Aetna HealthAssurance Pennsylvania, Inc.

Dear Mr. Farber:

Attached please find the Order by which the Insurance Commissioner of the Commonwealth of Pennsylvania has approved the referenced transaction.

Please note the conditions to the Order. Additionally, in accordance with 31 Pa. Code § 25.17(c), a Form B must be filed with the Department within 15 days of the end of the month in which the referenced acquisition is consummated. Questions concerning the Form B filing requirements should be directed to Steven Bordlemay, Financial Analysis Division at (717) 425-7294 / [sbordlemay@pa.gov](mailto:sbordlemay@pa.gov).

Please feel free to contact me at (717) 783-2144 should you have any questions concerning the approval Order.

Sincerely,



Cressinda E. Bybee  
Chief, Company Licensing Division

Attachment

cc: Steven Bordlemay  
Financial Analyst

**BEFORE THE INSURANCE COMMISSIONER**  
**OF THE**  
**COMMONWEALTH OF PENNSYLVANIA**

IN RE

Application of CVS Health Corporation for : Pursuant to Sections 1401, 1402 and 1403  
Approval of the Acquisition of Control of : of the Insurance Holding Companies Act,  
Aetna Health Insurance Company, Aetna : Article XIV of the Insurance Companies  
Better Health Inc., Aetna Health Inc., : Law of 1921, Act of May 17, 1921, P.L.  
HealthAssurance Pennsylvania, Inc., and : 682, as amended, 40 P.S. §§ 991.1401 –  
Aetna HealthAssurance Pennsylvania, Inc. : 991.1403; and Chapter 25 of Title 31 of The  
: Pennsylvania Code, 31 Pa. Code §§ 25.1 –  
: 25.23  
:  
: Order No. ID-RC-18-14  
:  
:  
:

**DECISION AND ORDER**

AND NOW, on this 26<sup>th</sup> day of October, 2018, Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania (“Commissioner”), hereby makes the following Decision and Order.

Pursuant to the Insurance Holding Companies Act and in consideration of the documents, presentations and reports received, as well as other inquiries and studies as permitted by law, the Commissioner makes the following findings of fact.

**FINDINGS OF FACT**

**Identity of Involved Parties**

Identity of Insurers to be Acquired (collectively, the “**Domestic Insurers**”) and Related Parties.

1. Aetna Health Insurance Company is a domestic stock life insurance company organized pursuant to the laws of the Commonwealth of Pennsylvania with its home office located in Blue Bell, Pennsylvania.
2. Aetna Better Health Inc. is a domestic stock health maintenance organization organized pursuant to the laws of the Commonwealth of Pennsylvania with its home office located in Blue Bell, Pennsylvania.

3. Aetna Health Inc. is a domestic stock health maintenance organization organized pursuant to the laws of the Commonwealth of Pennsylvania with its home office located in Blue Bell, Pennsylvania.
4. HealthAssurance Pennsylvania, Inc. is a domestic stock risk assuming preferred provider organization organized pursuant to the laws of the Commonwealth of Pennsylvania with its administrative office located in Blue Bell, Pennsylvania.
5. Aetna HealthAssurance Pennsylvania, Inc. is a domestic stock risk assuming preferred provider organization organized pursuant to the laws of the Commonwealth of Pennsylvania with its home office located in Blue Bell, Pennsylvania.
6. Aetna Inc. is a Pennsylvania corporation ("**Aetna**") and a publicly traded holding company for various insurance companies, health maintenance and dental maintenance organizations and related organizations, including the Domestic Insurers.

#### Identity of the Applicant and Related Parties.

7. CVS Health Corporation is a Delaware corporation ("**CVS Health**" or the "**Applicant**") and a publicly traded holding company, which, through its affiliates and subsidiaries, is (a) an integrated pharmacy health care company with more than 9,800 retail pharmacy locations and 1,100 walk-in health care clinics, (b) a leading pharmacy benefits manager with more than 94 million plan members, (c) a senior pharmacy care business serving more than one million patients per year, (d) a provider of specialty pharmacy services and (e) a leading standalone Medicare Part D prescription drug plan.
8. Hudson Merger Sub Corp. is a Pennsylvania corporation and a wholly-owned subsidiary of CVS Health ("**Merger Sub**").
9. SilverScript Insurance Company is a Tennessee domiciled stock insurance company and wholly-owned subsidiary of CVS Health ("**SilverScript**"). SilverScript is a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. This coverage is for standalone PDP coverage and does not include any Medicare Advantage coverage.

#### **Acquisition Filing**

10. On January 10, 2018, CVS Health filed an application on Form A - Statement Regarding the Acquisition of Control of or Merger with Domestic Insurers (the "**Form A**" or the "**Application**") with the Pennsylvania Insurance Department (the "**Department**") to obtain the approval of the Department to acquire control of the Domestic Insurers pursuant to Section 1402 of the Insurance Holding Companies Act ("**Section 1402**").

#### **Description of the Proposed Acquisition**

11. As described in the Application, on December 3, 2017, CVS Health, Aetna, and Merger Sub, entered into an Agreement and Plan of Merger (the "**Merger Agreement**"), pursuant to which, subject to the satisfaction or waiver of certain conditions, Merger Sub will be

merged with and into Aetna, with Aetna surviving the merger as a wholly-owned subsidiary of CVS Health, which will be the ultimate parent of, and thus control, Aetna and the Domestic Insurers (the “**Merger**”) and that at the effective time of the Merger (the “**Effective Time**”), each Aetna common share (other than treasury shares held by Aetna and any shares beneficially owned by CVS Health or any of CVS Health’s subsidiaries unless such shares are owned in a fiduciary, representative or other capacity on behalf of other persons) will be converted into the right to receive (i) 0.8378 shares of CVS Health common stock and (ii) \$145.00 in cash, without interest.

12. Following the Merger, Aetna would become an indirect wholly-owned subsidiary of CVS Health and a direct wholly-owned subsidiary of CVS Pharmacy, Inc. (“**CVS Pharmacy**”), a Rhode Island corporation which is a direct wholly-owned subsidiary of CVS Health.
13. As described in the Application and pursuant to the Merger Agreement, following the Merger, the Applicant would become the sole ultimate controlling person of the Domestic Insurers.

#### **Other Regulatory Filings**

14. On January 2, 2018, pursuant to Section 7A of the Clayton Act, CVS Health filed a Notification and Report Form For Certain Mergers and Acquisitions with the Premerger Notification Office of the United States Federal Trade Commission and the United States Department of Justice (the “**DOJ**”) regarding the Merger.
15. Nearly contemporaneously with the filing of the Form A with the Department, CVS Health filed applications for approval of CVS Health’s acquisition of certain health insurer affiliates of the Domestic Insurers and other required filings with the insurance departments or appropriate regulatory agencies in numerous other states including Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia and Wisconsin, and the District of Columbia (collectively, the “**State Regulators**”).

#### **The Proposed Divestiture**

16. CVS Health has reported that, on September 26, 2018, Aetna and a subsidiary of WellCare Health Plans, Inc. (“**WellCare**”) entered into an asset purchase agreement and related agreements pursuant to which (a) WellCare has agreed to acquire Aetna’s entire standalone Medicare Part D prescription drug plan business (but does not include Aetna’s individual or group Medicare Advantage, Medicare Advantage Part D or Medicare Supplement products or plans) which had an aggregate of approximately 2.2 million members at June 30, 2018 for a purchase price that is not material to Aetna, subject to the closing of the Merger, regulatory approvals and other customary closing conditions (the “**Divestiture**”) effective 11:59 p.m. ET on December 31, 2018 and (b) Aetna has agreed to provide administrative services to, and retain the financial results of, the divested business through

2019. CVS Health and Aetna have reported that they believe the Divestiture was a significant step toward completing the DOJ's review of the Merger.

### **Asserted Efficiencies and Public Benefits**

17. CVS Health purports that there are near-term and longer-term benefits of the Merger. Near-term purported benefits are those benefits that are achievable from the Merger within one (1) to two (2) years using existing capacity and capabilities of the Merger and include traditional opportunities expected from any merger and acquisitions transaction (e.g., rationalization of corporate functions and efficiencies in operations) as well as opportunities that come from combining CVS Health's pharmacy benefit management and retail businesses with Aetna's health plan (e.g., improved formulary management), and medical cost reduction opportunities that are possible by leveraging existing capacity and capabilities (e.g., reducing hospital readmissions, improving medical adherence, reducing unnecessary emergency room visits and sifting lab services and infusion services to less costly alternatives). CVS asserts that in the near-term the Merger would combine complementary businesses which it anticipates will reduce costs for payors, patients, CVS Health and Aetna, improve access to care, and improve the quality of care through a consumer-centric approach that would build community health hubs to make care more convenient and effective with regular patient contact and a broad suite of services.
18. Within five (5) years after the Merger, CVS Health asserts that longer-term benefits that require a higher level of integration, additional investment and time to realize will be achieved. The purported long-term benefits of the Merger include (a) reducing medical costs by better managing high-cost chronic care patients and reducing waste in health plan medical spend, (b) shifting the site of care to achieve savings made possible by leveraging the Applicant's lower-cost sites of care (e.g., MinuteClinic and Coram home infusion services), (c) increasing Medicare presence by enhancing Medicare Advantage ("**MA**") Star ratings, (d) improving prescription drug program ("**PDP**") to MA conversion and risk coding, (e) improving healthcare services value by combining joint assets (e.g. developing an improved care management platform by combining medical data with pharmacy claims), (f) growing customer base by improving medical costs for administrative services organization (ASO) clients, (g) providing a better integrated value proposition to shared clients, and (h) providing additional merger and acquisition opportunities given new areas for core and adjacent growth (e.g. Managed Medicaid and new healthcare services).

### **DOJ and State Regulators' Approvals**

19. The DOJ approved the Merger on October 10, 2018, subject to certain conditions, including the Divestiture.
20. As of the date hereof, a majority of the State Regulators have approved the transaction, in certain cases subject to various conditions.

### **Department Procedures**

21. On February 3, 2018, the Department published notice in the *Pennsylvania Bulletin* that the Application was submitted by CVS and such notice invited interested persons to submit

comments to the Department regarding the Application for 30 days following the date of the publication (“**Comment Period**”).

22. The Department has received one formal comment regarding the Application (“**Public Comment**”), albeit outside the Comment Period.
23. The Public Comment asserted that the Acquisition would reduce health care market competitiveness, endanger patient safety, and lessen quality of care in Pennsylvania.
24. CVS Health provided a response to the Public Comment.
25. Section 1402 provides that the Department may retain, at the acquiring party’s expense, any attorneys, actuaries, accountants and other experts not otherwise part of the Department’s staff as may be reasonably necessary to assist the Department in reviewing the proposed acquisition of control.
26. The Department retained Cozen O’Connor (“**Cozen**”) to act as its legal advisor in connection with the matters relating to the Department’s examination of the proposed Acquisition.
27. Cozen retained Love and Long, LLP (“**Love and Long**”) to act as co-legal advisor in connection with the matters relating to the Department’s examination of the proposed Acquisition.
28. Cozen engaged Economists Incorporated (“**EI**”) as an economic advisor to assist it in its review of the Application including performing economic analysis concerning the proposed Acquisition.
29. EI prepared a report (the “**EI Report**”) for the Department which is incorporated herein by reference.
30. In determining whether to approve the Application, the Department considered materials submitted by CVS Health, other information, presentations, reports, documents, the Public Comment and other inquiries, investigations, materials and studies permitted by law.
31. The Department specifically considered the report prepared for it by EI in determining whether to approve the Application.
32. Section 1402 provides that the Commissioner shall conduct a hearing if either the acquiring party or the party to be acquired requests a hearing within ten (10) days of the filing of the Application. A hearing may also be held if the Commissioner, in her discretion, elects to conduct a hearing as part of her review and analysis of the Form A.
33. Neither CVS Health nor Aetna requested a hearing on the Application.
34. Because the Applicant did not request a hearing, the decision to conduct a hearing was within the Commissioner’s discretion under Section 1402.

35. The Commissioner exercised her discretion to not hold a public informational hearing on the Application.
36. The Commissioner's decision to not hold a public informational hearing was an appropriate exercise of her discretion under Section 1402.

### **CVS' Business**

37. CVS Health, through CVS Caremark ("**Caremark**"), is a leading pharmacy benefits manager ("**PBM**") with more than 94 million plan members and provides a full range of pharmacy benefit management services including pharmacy benefit plan design offerings and administration, formulary management, Medicare Part D services, mail order pharmacy, specialty pharmacy, retail pharmacy management, prescription-management systems, clinical services, disease management programs and medical benefit management to clients consisting primarily of employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, through SilverScript, CVS Health is a national provider of drug benefits to eligible beneficiaries under the federal government's Medicare Part D program. This coverage is for standalone PDP coverage and does not include any Medicare Advantage coverage.
38. As a PBM, Caremark manages the dispensing of prescription drugs through its mail order pharmacies, specialty pharmacies, national network of long-term care pharmacies and more than 68,000 retail pharmacies (which dispense prescriptions, provide patient counseling, monitor medication adherence and recommend cost-effective drug therapies), consisting of approximately 41,000 chain pharmacies (which includes its CVS Pharmacies) and 27,000 independent pharmacies, to eligible members in the benefit plans maintained by its clients.
39. Since 2011, Caremark has performed PBM functions for Aetna for its standalone PDP products and its Medicare Advantage Part D prescription drug products. The services provided by Caremark to Aetna include formulary management, dispensing mail-order and specialty drug prescriptions, claims processing, negotiating rebates for Medicare and Medicaid prescription, administering all rebate claims, and providing various care management and clinical programs to Aetna members.
40. As of December 31, 2017, CVS Health, through its subsidiary CaremarkPCS, L.L.C., operated 23 retail specialty pharmacy stores that address the pharmaceutical needs of individuals with certain chronic or genetic diseases, 18 specialty mail order pharmacies and four mail order dispensing pharmacies, and 83 branches for infusion and enteral services, including approximately 73 ambulatory infusion suites and three centers of excellence, located in 42 states, Puerto Rico and the District of Columbia.
41. During the year ended December 31, 2017, Caremark filled or managed approximately 1.8 billion prescriptions on a 30-day equivalent basis.

42. As of December 31, 2017 in its retail operations, CVS Pharmacy operated 9,803 retail stores (of which 8,060 were stores that operated a pharmacy and 1,695 were pharmacies located within Target stores located in 49 states, the District of Columbia, Puerto Rico and Brazil, 37 onsite pharmacies, and 1,134 retail health care clinics operating under the MinuteClinic name which provide immediate care services, and three online retail websites, CVS.com, Navarro.com and Onofre.com.br.
43. In its retail operations, CVS Health, through its subsidiary Omnicare, Inc., also provides for the distribution of pharmaceuticals, related pharmacy consulting and other ancillary services to chronic care facilities, skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers through 145 spoke pharmacies that primarily handle new prescription orders, of which 30 are also hub pharmacies that use proprietary automation to support spoke pharmacies with refill prescriptions.

#### **Aetna's Business**

44. Aetna is a publicly traded Pennsylvania holding company for various insurance companies, health maintenance and dental maintenance organizations and related organizations.
45. Aetna is one of the nation's leading diversified health care benefits companies, serving an estimated 46 million people.
46. Aetna offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, vision, behavioral health, stop loss, group life and disability plans, medical management capabilities, Medicaid health care management services, Medicare Advantage and Medicare Supplement plans, workers' compensation administrative services and health information technology products and services. Aetna's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates.
47. Aetna also offers PBM services for Aetna pharmacy customers consisting of product development, commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs, and specialty and home delivery pharmacy services and dispenses specialty medications (which are injectable or infused medications that may not be readily available at local pharmacies) and offers certain support services associated with specialty medications.
48. At December 31, 2017, Aetna's underlying nationwide provider network had approximately 1.2 million participating health care providers, including over 683,000 primary care and specialist physicians and approximately 5,700 hospitals.
49. Aetna has Medicare Advantage and PDP contracts with Centers for Medicare & Medicaid Services ("CMS") to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas.



## **Distributions and Future Plans**

50. CVS Health stated in the Applicant it has no present plans or proposals following the closing of the Merger to cause the Domestic Insurers to declare any extraordinary dividend, to liquidate the Domestic Insurers, to sell any material portion of the assets of the Domestic Insurers, to merge them with any other person or persons or to make any other material change in the Domestic Insurers' business, corporate structure, management or general plan of operations.
51. As stated in the Application, from time to time following the closing of the Merger, CVS Health may assess the advisability of causing one or more of the Domestic Insurers to declare a dividend, but any such determination and any declaration would be effected in compliance with all applicable statutory and regulatory requirements.
52. As stated in the Application, following the closing of the Merger, the Domestic Insurers will maintain their separate corporate existence and will be indirect wholly-owned subsidiaries of CVS Health.
53. As stated in the Application, no specific material changes in the Board of Directors or senior management or operations of the Domestic Insurers are currently planned as part of the Merger or immediately after the Merger other than to replace any current Board members or employees who may resign following the closing of the Merger.

## **Standards for Review**

54. Section 1402(f)(1) of the Insurance Holding Companies Act established the standards for approval of an application for a change of control of a domestic insurer.
55. An application for a change in control must be approved unless the Department finds any one of certain enumerated conditions to be present.

### Licensing Requirements.

56. When analyzing an application for a change of control under Section 1402, the Department reviews the requirements for continued licensure of the domestic insurers subject to the change of control.
57. Specifically, the Department reviews whether after the change of control each Domestic Insurer would be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed after the acquisition. See 40 P.S. § 991.1402(f)(1)(i).
58. The lines of insurance for which an insurance company may be incorporated and become licensed to write are set out in Section 206 of the Insurance Company Law, 40 P.S. § 386.
59. In order to satisfy the requirements of a license to write the relevant lines of insurance, the Domestic Insurers must meet certain statutory minimum capital balance requirements.

60. The minimum statutory capital balance requirements for each Domestic Insurer and the actual capital balance for each Domestic Insurer are as indicated in the following Table 1:

**TABLE 1  
STATUTORY MINIMUM AND ACTUAL CAPITAL BALANCES  
OF DOMESTIC INSURERS**

(\$ in thousands)	Minimum Capital Balance			Minimum Paid In Surplus Balance			Minimum Net Worth Balance		
	Q2 2018	Requirement	Satisfy	Q2 2018	Requirement	Satisfy	Q2 2018	Requirement	Satisfy
Aetna Health Insurance Company (Life)	\$2,501,000	\$1,100,000	YES	\$37,516,449	\$550,000	YES	--	--	NA
Aetna Better Health Inc. (HMO)		--	NA		--	NA	\$134,418,868	\$1,500,000	YES
Aetna Health Inc. (HMO)		--	NA		--	NA	\$526,432,544	\$1,500,000	YES
HealthAssurance Pennsylvania, Inc. <sup>(1)</sup>		--	NA		--	NA	\$173,953,072	\$1,175,000	YES
Aetna HealthAssurance Pennsylvania, Inc. <sup>(2)</sup>		--	NA		--	NA	\$45,517,631	\$1,175,000	YES

61. Based on the second quarter of 2018 capital, surplus and net worth balances of the Domestic Insurers, as applicable, each Domestic Insurer would be able to satisfy the requirements for the issuance of a license to write the lines of insurance for which it is presently licensed upon completion of the Merger, and the Department does not find that any changes are likely to result from the Merger.

### Competitive Impact

62. The Merger is subject to review and analysis under Section 1402(f)(1)(ii) and the applicable parts of Section 1403 of the Insurance Holding Companies Act (“**Section 1403**”) to determine whether the effect of the Merger would be to substantially lessen competition or tend to create a monopoly in the Commonwealth. 40 P.S. § 991.1402(f)(1)(ii) (the “**Competitive Standard**”).
63. In applying the Competitive Standard, the informational requirements of Section 1403(c)(2) and the standards of Subsection (d)(2) of Section 1403 are applicable.
64. Pursuant to Section 1403(d), the Department may enter an order under Section 1403(e)(1) with respect to a merger if there is substantial evidence that the effect of the merger may be substantially to lessen competition in any line of insurance in the Commonwealth or

<sup>1</sup> HealthAssurance Pennsylvania, Inc. is a risk assuming preferred provider organization that is not a licensed insurer a/k/a RANLI PPO.

<sup>2</sup> Aetna HealthAssurance Pennsylvania, Inc. is a risk assuming preferred provider organization that is not a licensed insurer a/k/a RANLI PPO.

tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with Section 1403(c).

65. The Department requested from the Applicant additional material and information to determine whether the Merger, if consummated, would violate the competitive standard of Section 1403(d) and the Department through its consultant undertook a review of relevant factors relating to competition.

66. Based upon such review, the EI Report concluded, and the Department so finds, that:

(a) Based on the overall evaluation of the available information related to the sale of PBM, retail pharmacy, and immediate care services in Pennsylvania, the Merger is unlikely to result in harm to competition in any markets in the Commonwealth. Nevertheless, competitive conditions for each of these services can vary by geographic area within Pennsylvania, among certain types of customers, and over time.

(b) Regarding markets in which both CVS Health and Aetna provide services (i.e., horizontal competition), the potential harm to competition is unlikely, in part because CVS Health plans to divest the stand-alone Medicare prescription drug program ("PDP") business of Aetna.

(c) Currently, CVS Health supplies PBM, retail pharmacy, and immediate care services to Aetna as well as to some other health plans that are competitors of Aetna. Various theories exist that an integrated CVS Health-Aetna would have an economic incentive to deal with Aetna's health plan competitors in ways that disadvantage those health plans in competing with Aetna.

(d) The empirical analysis shows that that, based on current market conditions, it is unlikely that CVS Health's integration with Aetna will give it the power to harm Aetna's competitors. The economic gain that CVS Health might achieve in health plan markets from an attempt to disadvantage Aetna's competitors would likely be too small to offset the economic loss that strategy would incur in CVS Health's PBM, retail pharmacy, and immediate care businesses.

(e) Information gathered from interviews with Pennsylvania health plans that purchase PBM, retail pharmacy, and immediate care services was not entirely consistent with the empirical analysis. The health plans expressed concerns that the integration of CVS Health and Aetna would affect their ability to receive competitive bids for PBM, retail pharmacy, and/or immediate care services. The concerns raised by the health plans are most plausible for plans or large employers with particular needs that either an integrated CVS Health alone or few other entities can satisfy. It is possible that such idiosyncratic circumstances exist among health plans or large employers in Pennsylvania.

(f) Regarding the PBM market, which may be highly concentrated, the transaction is unlikely to enhance the market power of Caremark or other participants, primarily because Aetna is not a likely entrant into the PBM market and would not likely facilitate some other entrant but-for the Merger.

(g) The Applicant represented that significant efficiencies will flow from the Merger, including savings from combining the companies' separate operational, financial, reporting and corporate functions and integrating the companies' technologies, products and services. In addition, the parties project longer term medical savings related to better management of chronic conditions and medication adherence as well as redirection of patient care to lower cost providers. While the Department does not have sufficient information to evaluate the accuracy of these claimed savings, they potentially could benefit consumers through reduced premiums and enhanced quality of care to the extent that they are realized.

67. As indicated above, EI's empirical analysis leads to the conclusion that on balance, the Merger is unlikely to result in harm to competition in any of the markets in which the parties participate, either through horizontal concentration or through a vertical theory of harm. Nevertheless, the concerns expressed by health plans in Pennsylvania warrant certain actions by the Department to ensure that conditions do not change in a manner that could result in competitive harm or that idiosyncratic circumstances enable CVS Health to exercise market power against specific purchasers in any of these markets.
68. With the imposition of the conditions set forth in the Order that are designed to preserve and promote competition in insurance in the Commonwealth and to protect the public interest, the Department concludes that the Merger and the transactions described in the Application do not violate the Competitive Standard. The conditions permit the substantive benefits contemplated by the Merger and the associated transactions while limiting the risks of adverse competitive effects.

#### **Horizontal Overlap in Medicare Prescription Drug Programs**

69. The standard for the Department to determine whether a horizontal combination is presumed to cause harm to competition is set forth in Section 1403. Section 1403 considers markets in which the top four competitors have a combined share of more than 75% to be highly concentrated. In such markets, a prima facie violation of the Competitive Standard occurs when merging parties' shares are as follows:

**[CONTINUED ON NEXT PAGE]**

**TABLE 2**  
**Prima Facie Violation of Competitive Standards**  
**Highly Concentrated Market**

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

70. If the market is not highly concentrated, a prima facie violation of competitive standards occurs when merging parties' shares are as follows:

**TABLE 3**  
**Prima Facie Violation of Competitive Standards**  
**Non-Highly Concentrated Market**

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

71. Standalone PDP services are available in the CMS region for Pennsylvania and West Virginia ("**Region 6**"). CVS Health, Aetna and other competitors market standalone PDP services region-wide. Both CVS Health and Aetna are sellers of standalone PDP services and Aetna also sells Medicare Advantage prescription drug ("**MAPD**") services. Aetna, but not CVS Health, also sells combined MAPD services in counties in Pennsylvania.
72. MAPD services are sold within specific counties in Pennsylvania, but the same sellers often sell in multiple counties and there are no barriers that impede sellers within a subset of counties to sell their products state-wide, or indeed in all of Region 6. EI also noted considerable variation in the parties' and their competitors' shares across individual

Pennsylvania counties. As a result, Region 6, the Commonwealth of Pennsylvania, and individual counties are all potential geographic markets.

73. The theory of harm related to a horizontal overlap between CVS Health and Aetna is that the Merger would reduce alternatives for PDP services and increase concentration in a competitively significant manner thus leading to above-competitive pricing or below-competitive quality.

#### **The Evidence for Standalone PDP and MAPD/PDP Products in Pennsylvania**

74. CVS Health has committed to divesting the standalone PDP business of Aetna, thereby eliminating any overlap with CVS's standalone PDP business. The Divestiture implies that Aetna's share of standalone PDP business in Pennsylvania and in Region 6 will be zero. As a result, the parties' shares in the standalone PDP market do not meet the thresholds established in Section 1403 to provide evidence of a prima facie violation of competitive standards.
75. To the extent that combined PDP/MAPD constitute a relevant product market, a competitive overlap would remain in that market. The parties' and their competitors' shares for the combined product, based on September 2018 enrollment data from CMS, are shown in Table 4 below.

**[CONTINUED ON NEXT PAGE]**

**TABLE 4**  
**PDP/MAPD Enrollment Shares for Region 6 and Pennsylvania**  
**September 2018**

Health Plan	Region 6	Pennsylvania
Aetna Life Insurance Company	11.8%	12.3%
CVS Health/Silverscript Insurance Company	14.7%	14.8%
Aetna + CVS Health	26.5%	27.1%
Highmark	12.3%	13.8%
UnitedHealthCare	12.0%	11.9%
Humana	12.7%	9.5%
UPMC	7.2%	8.4%
Independence Blue Cross	4.5%	5.1%
Medco (Express Scripts)	5.1%	4.7%
Geisinger Health	3.8%	4.4%
Wellcare Prescription Insurance, Inc.	4.6%	4.4%
Cigna Health and Life Insurance Company	3.6%	3.6%
Envision Insurance Company	3.5%	3.5%
Capital Blue Cross	1.4%	1.6%
Health Partners Plans, Inc.	0.8%	0.9%
All Others	2.0%	1.1%

**Note:** Aetna's stand-alone PDP enrollment is attributed to Wellcare.

**Sources:** CMS PDP and MAPD enrollment data, September 2018.

76. For both Region 6 and Pennsylvania, combined shares of the top four competitors for MAPD/PDP exceed the 75% four-firm threshold for highly concentrated markets, as defined in Section 1403. In each of these areas, the merging parties have shares of least 5% each, thus triggering a finding of prima facie evidence of a violation of the competitive standard according to Section 1403.<sup>3</sup>

<sup>3</sup> This analysis takes into account the Divestiture by Aetna of its stand-alone PDP enrollment to WellCare.

77. Section 1403 provides that despite the presence of a prima facie violation of competitive standards, the parties may demonstrate the absence of anticompetitive effects based upon factors such as market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.
78. Table 4 shows that several PDP/MAPD competitors have shares that are comparable or a few percentage points below Aetna's and CVS Health's, including Highmark, UnitedHealth Care, Humana, UPMC, Independence Blue Cross and ESI. Since they do not face barriers to expansion and could easily expand, these competitors will likely continue to provide vigorous competition to the merged entity post-merger.<sup>4</sup>

### **Vertical Foreclosure of PBM Services to Competing Health Plans**

79. Some health plans in Pennsylvania maintain that only three PBM service providers have sufficiently sophisticated capabilities to manage the complexity of such plans' prescription-drug benefits. The three PBMs are Caremark, Express Scripts and Optum. These three PBMs ostensibly have built high levels of IT infrastructure and developed substantial experience that enables them to handle multiple formularies, manage the unique demands of large self-funded accounts, migrate large accounts between health plans, provide sophisticated reporting tools, accommodate CMS audits, and negotiate aggressive discounts and rebates with manufacturers. In the view of these health plans, mid-sized and smaller PBMs do not have sufficient experience, skills, or scale to provide the necessary services.
80. It is not clear that the PBM services market is non-competitive notwithstanding that it includes a small number of large suppliers and a modest number of mid-sized suppliers. Even with small numbers of suppliers, PBM services typically are purchased through a bidding process that lends itself to competitive outcomes. Interviews with health plans identified examples of the use of the second-best bidder to leverage better prices and terms from the top bidder. In that bidding context, the bids of the third-best and other suppliers do not influence the final terms accepted by the health plan.
81. In addition to Caremark, two large PBM service providers – Express Scripts and Optum – are available and already used by non-integrated health plans in Pennsylvania. They are commonly among the bidders responding to health plans' RFPs and are also included in market checks by health plans. The availability and ongoing use of two other large PBMs by health plans in Pennsylvania suggests that CVS Health faces a significant risk that health plan customers would substitute away from Caremark if it attempted to increase PBM prices. CVS Health's business documents discuss these risks and state a need to offer competitive discounts to retain existing business. Even if all three large PBMs became vertically integrated and each had an incentive to favor its own health plan, they would all retain the competitive incentive to take customers from each other, thereby not changing the current competition among PBMs.

---

<sup>4</sup> Even though MAPD shares vary by county, the shares of the parties and their competitors were such that, even if individual counties were the geographic market, the conclusion would not change.



82. Also informative to the competitiveness of PBM markets are the profit margins of suppliers. If the PBM market were non-competitive, it would be expected to produce above-competitive profits. Publicly available information and CVS data reflect only modest and declining profitability of PBMs. This margin information is not consistent with concentration in PBM markets having created market power.
83. The profitability of a vertical foreclosure strategy by CVS Health is determined by comparing the profit gains from sales diverted to Aetna (i.e., increased health plan revenue times contribution margin) and the profits lost from health plans switching PBM services away from Caremark.
84. One way to measure the balancing of these economic forces is with the “vGUPPIu” which stands for Vertical Gross Upward Pricing Pressure Index for the Upstream rival. The formula for the vGUPPIu takes into account the various factors described above and measures the financial incentive of a vertically integrated entity to raise the price of inputs it sells to downstream rivals.
85. With data provided by CVS Health and from public sources, the vGUPPIu for CVS Health in Pennsylvania is calculated to be small under different reasonable assumptions. Using the standard model for diversion described above, the likelihood of Aetna capturing health plan sales from other disfavored rival plans is low because Aetna’s shares are low in the regions where potentially disfavored Pennsylvania insurers also compete. Not only is the likelihood of Aetna capturing diverted health plan enrollment small, but the enrollment it might capture would not be highly profitable. Consequently, the loss of PBM profits by CVS Health would likely be significant if it attempted to increase prices to Pennsylvania health plans.
86. The elasticity of demand by health plans for Caremark’s PBM services is likely to be high based on plans’ descriptions of their concerns over PBM costs, and the availability of alternative PBMs indicates that they could switch away from a high-cost PBM if needed. Consequently, the loss of PBM profits by CVS Health would likely be significant if it attempted to increase prices to Pennsylvania health plans. Therefore, the vGUPPIu, or the measure of the economic incentive of CVS Health to engage in input foreclosure is small.
87. Regardless of the availability of sufficient PBM alternatives, some Pennsylvania health plans have expressed concern that all three large PBMs will be integrated with one of the health plans’ direct competitors. While the vGUPPIu analyses indicate that incentives to foreclose are not present for CVS Health including its affiliates and the Domestic Insurers (collectively “CVS-Aetna”), the health plans are nevertheless concerned that access to their competitively sensitive information could deliver an unfair advantage to their integrated competitors. The Department concludes that the imposition of the firewall condition set forth in the Order are sufficient to address such concerns.

## **Vertical Foreclosure of Retail Pharmacy Services to Competing Health Plans**

88. An integrated retail pharmacy provider could, in theory, increase prices or restrict availability of access to retail pharmacy services to enrollees of competing health insurance plans. The integrated entity could earn higher profits from this strategy if (a) retail pharmacy network services markets are insufficiently competitive, (b) at least some of the cost increase of retail pharmacy services is passed on to the competing health plan's enrollees, and (c) the integrated entity's health plan could capture enough diverted sales to make the overall strategy profitable.
89. In addition to CVS Health, providers of retail pharmacy services in Pennsylvania include drug store chains like Rite Aid and Walgreens, both of which compete head-to-head with CVS Health in all or parts of the state. Other providers of retail pharmacy network services include grocery stores like Giant Eagle and Weiss, big box stores like WalMart, and independent pharmacies. There are 1.8 times as many independent stores in Pennsylvania as CVS pharmacies. Independent pharmacies are commonly contracted through affiliated groups like groups such as, McKesson's Health Mart Atlas, AmerisourceBergen's Elevate Provider Network, and Arete Pharmacy Network. Subsets of these providers are widely available in many communities in Pennsylvania.
90. The competitiveness of retail pharmacy network services is reinforced by the same bidding process as is used for PBM services. The bidding process does not require a large number of bidding pharmacy network providers to reach a competitive outcome. If a PBM does not own a retail network, it contracts with pharmacies to establish a sufficient network for its health plan customers. Few, if any, health plans rely solely on a single retail pharmacy chain, including CVS Health's chain.
91. Even if the alternative retail pharmacies available in Pennsylvania are considered to be insufficient to protect health plans from vertical foreclosure and above-competitive pricing from CVS Health, health plans might be protected from a foreclosure strategy by CVS Health if their contracts with CVS Health are part of national or broad regional contracts or if they switch away from a "pass-through" contract with pharmacy and network service providers that contract directly with CVS Health for retail pharmacy services on behalf of an individual plan to a broader national model.
92. Insofar as vertical foreclosure of CVS pharmacies reduces sales of profitable non-prescription drug items that are purchased along with prescription drugs, the higher lost profits per prescription drug sale are that much more difficult to offset by increased enrollment in Aetna products.
93. Based on the economic analysis, there appears to be only a small economic incentive to CVS Health to foreclose its retail pharmacy network from competing health plans.
94. Health plans, however, described CVS as an important supplier of retail pharmacy services, explaining that it would be very disruptive for customers if CVS retail pharmacies were dropped from their current pharmacy networks. As discussed above, however, industry trends appear to indicate that it is increasingly feasible for health plans to offer preferred or limited networks that exclude CVS retail pharmacies, at least for some portion of their

enrollees. Some plans indicated that restricted retail pharmacy networks without CVS pharmacies could be marketed in narrow-network products by using some combination of Walgreens, Rite Aid, independent pharmacies, grocery stores, and big box stores. But others were skeptical of the acceptability of those networks.

95. If enrollees left a health plan because of dissatisfaction related to CVS pharmacies not being in-network, those enrollees are more likely to change to Aetna or other plans where access to CVS pharmacies would be assured. To the extent CVS is a "must-have" provider for some portion of a health plan's retail pharmacy network, and the integrated entity can successfully target that health plan, the transaction potentially creates an incentive for CVS Health to foreclose the health plan. Since at least two of every three pharmacies in each county are unaffiliated, CVS Health's retail network of pharmacies can only be a "must-have" if enrollees have a strong preference for CVS despite the availability of other alternatives. At least some Pennsylvania health plans perceive that such preferences do exist.

### **Vertical Foreclosure of Immediate Care Services to Competing Health Plans**

96. An equivalent theory of vertical foreclosure applies to immediate care services, such as those provided in CVS MinuteClinics. An ability to foreclose health plan rivals through higher prices for MinuteClinic services hinges critically on the competitiveness of the market within which immediate care services are offered. Due to low entry barriers for the provision of such services, and substitutability with urgent care, primary care and other types of providers, it is unlikely that the market lacks sufficient competition. Further, there are only 34 MinuteClinics in Pennsylvania. In contrast, there are 281 urgent care centers in the Commonwealth. These facts indicate that immediate care services presently are offered in competitive markets and that an integrated CVS Health would not have an ability to foreclose Aetna's rivals by raising its prices for MinuteClinics.
97. Some health plans, however, raised concerns that an integrated CVS Health would have an ability to foreclose them by increasing their prices for MinuteClinic services.

### **Entrenched Concentration in the PBM Market**

98. There is little, if any, evidence that prices in the PBM market are above-competitive, notwithstanding the market structure. Rather, the bidding process of PBM service providers to win contracts with health plans does not require large numbers of sellers to result in competitive prices and quality.
99. Moreover, CVS and Aetna do not overlap as suppliers of PBM services, so the Merger will not increase concentration in the PBM services market.
100. No evidence has arisen that Aetna was a likely potential entrant into PBM services or that its enrollment was a critical element of any other entity's planned entry into the PBM services market. To the extent Aetna were a likely entrant, other insurers such as Humana and coalitions of provider-led plans would remain as potential entrants as well.

101. The vertical integration between CVS Health and Aetna is projected by CVS Health to create efficiencies that lower costs to enrollees which is good for consumers. Those efficiencies may make it more difficult for a potential entrant to effectuate entry, but to deny those cost-reducing efficiencies would harm consumers.

### **Competitively Sensitive Information**

102. CVS Health affiliates and Aetna affiliates engage in confidential and competitively sensitive contract negotiations with each other's rivals that involve price and non-price terms and product design. Common ownership of CVS-Aetna provides the opportunity for each to obtain and make use of competitively sensitive information from rivals that could be used to the potential detriment of consumers and competition. The Merger also causes a potential concern that CVS-Aetna would be able to exercise control over contracting with the potential to include contracting provisions that would tend to disadvantage competitors.
103. The risk that competitors' confidential information could be put to an improper use increases significantly because of the Merger. This may include present and future reimbursement rates, payor-provider reimbursement contract, reimbursement methodologies, formulary development, rebate, discounts, etc.
104. The ability of rival insurers, health care providers and PBMs to develop and obtain the benefits of innovative products and pricing depend on their ability to contract with CVS-Aetna affiliated providers, PBMs, insurers and pharmacies without the risk of disclosure of competitively sensitive information to CVS-Aetna affiliates.
105. These problems are mitigated by the firewall condition incorporated into the Order.

### **Asserted Benefits of the Merger**

106. CVS Health asserts in the Form A that the proposed Merger will:
  - (a) Combine two organizations with long-standing commitments to promoting health and wellness in their local communities and expanding access to high quality, affordable health care.
  - (b) Provide treatment at the best site of care and improve care across the continuum through greater collaboration among Aetna's in-network physician and hospital providers and more than 9,700 CVS Pharmacy locations, 1,100 MinuteClinic walk-in clinics, 140 long-term care pharmacies, and 80 infusion branches.
  - (c) Allow Aetna's in-network physician and hospital providers, CVS Health pharmacists, and MinuteClinic nurse practitioners to coordinate their activities through more effective use of pharmacy and medical claims data, to achieve better outcomes by ensuring that a patient's full health history is considered at all points of care.
  - (d) Lower patient and enrollee costs through the broader use of data and analytics. This will be achieved, for example, by improving chronic care management using pharmacist-led interventions and by boosting patients' adherence to medication and

treatment protocols. The combined company will also reduce avoidable hospital visits by growing use of MinuteClinics and by shifting infusion services from outpatient hospital settings to more convenient and lower-cost home settings when appropriate.

(e) Generate company-level savings opportunities by combining corporate functions, by obtaining improved pricing from third-party suppliers, and by merging complementary expertise in pharmacy and medical benefits, the benefits of which can be shared with clients, customers and patients.

*Overall Near-Term Cost Savings*

107. CVS Health has developed estimates of cost savings and efficiencies that it believes it can accomplish within the first year to two years after the Merger, and those that would be implemented in years three through five.
108. The near-term savings derive from traditional sources of savings like combining overlapping operations and eliminating duplicative corporate functions, as well as some medical cost savings stemming immediately from the combination, and from cost savings from improved care management and shifting care to lower-cost sites.

*Overall Longer-Term Cost Savings*

109. CVS Health estimates that overall longer-term cost savings from the Merger would come from medical cost savings related to chronic care and shifting patient care to lower-cost sites as appropriate.

*Estimated Savings Specific to Pennsylvania*

110. For its part, CVS Health has not provided significant information regarding the expected operating efficiencies, cost savings and other benefits currently anticipated from the Merger.
111. As the Applicant's strategy is reasonable and could provide significant benefits to Aetna's enrollees and to the Commonwealth as a whole, provided the firewall, "most favored nation" and reporting conditions set forth in the Order are adhered to, the Department has not found that the effect of the Merger would be to substantially lessen competition for insurance in this Commonwealth or tend to create a monopoly therein.

**Financial Condition of Applicant**

112. When analyzing an application for a change of control under Section 1402, the Department reviews the financial condition of the acquiring person as of the consummation of change of control.
113. The Department has reviewed the financial statements and the confidential financial projections and business plan submitted by CVS Health.

114. While the Applicant will incur substantial debt in connection with the Merger, the Department does not find that the financial condition of the Applicant is such that it might jeopardize the financial stability of the Domestic Insurers or prejudice the interests of policyholders as of the consummation of the Merger.

#### **Plans for the Domestic Insurers**

115. When analyzing an application for a change of control under Section 1402, the Department reviews the plans or proposals which the acquiring party has to liquidate any of the Domestic Insurers, to sell their respective assets, to consolidate or merge any of them with any person or persons, or to make any other material change in any Domestic Insurer's business or corporate structure or management is unfair and unreasonable and fails to confer a benefit on policyholders of the Domestic Insurers and is not in the public interest.
116. The Department reviewed the transaction as set forth in the Application to determine whether it is: (a) unfair or unreasonable or fails to confer a benefit upon policyholders; (b) is not in the public interest.
117. Subject to the conditions contained in the Order, including the reporting and monitoring of the asserted benefits to the public and policyholders of the Merger, the Department does not find that the plans or proposals CVS Health has to liquidate any of the Domestic Insurers, to sell their respective assets, to consolidate or merge any of them with any person or persons, or to make any other material change in any Domestic Insurer's business or corporate structure or management is unfair and unreasonable and fails to confer a benefit on policyholders of the Domestic Insurers and is not in the public interest.

#### **Management**

118. When analyzing an application for a change of control under Section 1402, the Department reviews the competence, experience and integrity of the persons who will control the operations of the acquired insurer.
119. Biographical affidavits for all directors and executive officers of CVS Health and Aetna (including the Domestic Insurers) were reviewed by the Department.
120. The current directors and executive officers of the Applicant are not currently expected to change as a result of the Merger except that, upon the closing of the Merger, the number of members of the CVS Health Board of Directors will be increased by three (3) and the vacancies created thereby will be filled by Aetna's Chairman and CEO Mark T. Beltoni and two other individuals who are serving on the board of directors of Aetna immediately prior to the closing of the Merger, who are jointly designated by Aetna and CVS Health and who meet CVS Health's independence criteria in effect as of such time. In addition, members of the Aetna management team will play significant roles in the newly combined company. Aetna will operate as a standalone business unit within the CVS Health enterprise and will be led by members of their current management team.

121. The Department is satisfied that the persons who would control the operations of CVS Health and Aetna (including the Domestic Insurers) have such competence, experience, and integrity that the interests of policyholders and the public would not be jeopardized.

#### **Hazardous or Prejudicial to Insurance Buying Public**

122. When analyzing an application for a change of control under Section 1402, the Department evaluates whether the merger, consolidation or other acquisition of control is likely to be hazardous or prejudicial to the insurance buying public.
123. Based upon the benefits of the Merger articulated by CVS Health, provided the conditions are complied with, the Merger does not pose a material risk to the Domestic Insurers' policyholders.
124. As it relates to the public at large, the Department and EI reviewed the Public Comment received concerning the Application, analyzed and considered information submitted by the Applicant and conducted private meetings with various market participants and other investigations. Based upon its review, the Department concludes that the imposition of the conditions is sufficient to make it not likely that the Merger would be hazardous or prejudicial to the insurance buying public.

#### **Compliance with Pennsylvania Laws**

125. When analyzing an application for a change of control involving a domestic insurer under Section 1402, the Department reviews the change of control to determine whether the merger, consolidation, or other acquisition of control is not in compliance with the laws of this Commonwealth.
126. The Department has evaluated the Merger as set forth in the Application as to whether it is in compliance with the laws of Pennsylvania.
127. The Department has not identified any provision of Pennsylvania law that the Merger would violate.

#### **INCORPORATION OF FINDINGS OF FACT AND CONCLUSIONS OF LAW**

If any of the below Conclusions of Law are determined to be findings of fact, they shall be deemed incorporated in the Findings of Fact as if fully set forth therein. If any of the above Findings of Fact are determined to be conclusions of law, they shall be deemed incorporated in the Conclusions of Law as if fully set forth therein.

## CONCLUSIONS OF LAW

1. Under Section 1402, the Department has jurisdiction to review and approve the change of control of the Domestic Insurers.
2. Section 1402 requires the Department to approve an application for a change of control unless the Department has found one or more of the following:
  - (a) After the change of control, any Domestic Insurers would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed; or
  - (b) The change of control would substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein; or
  - (c) The financial condition of the Applicant is such as might jeopardize the financial stability of one or more of the Domestic Insurers or prejudices the interests of any policyholders; or
  - (d) Any plans or proposals the acquiring party has to liquidate any of the Domestic Insurers, to sell their respective assets, to consolidate or merge any of them with any person or persons, or to make any other material change in any Domestic Insurer's business or corporate structure or management is unfair and unreasonable and fails to confer a benefit on policyholders of the Domestic Insurers and is not in the public interest; or
  - (e) The competence, experience and integrity of those persons who would control the operation of the Domestic Insurers are such that it would not be in the interest of the policyholders of the Domestic Insurers and of the public to permit the change of control; or
  - (f) The change of control is likely to be hazardous or prejudicial to the insurance buyer public; or
  - (g) The change of control is not in compliance with the laws of this Commonwealth.
3. Under Section 1402, the Department has jurisdiction to review and approve the Merger.
4. Under Section 1402, and subject to the conditions set forth in the Order, the Department has not found that any of the above conditions are present with respect to the Merger.
5. The Department finds that, with the imposition of the conditions set forth in the Order to preserve and promote competition in insurance in this Commonwealth and to protect the public interest, the Merger and all other transactions included in the Form A which are subject to the Department's jurisdiction and require approval of the Department do not violate Section 1402.



**BEFORE THE INSURANCE COMMISSIONER**  
**OF THE**  
**COMMONWEALTH OF PENNSYLVANIA**

IN RE:

Application of CVS Health Corporation for Approval of the Acquisition of Control of Aetna Health Insurance Company, Aetna Better Health Inc., Aetna Health Inc., Health Assurance Pennsylvania, Inc., and Aetna Health Assurance Pennsylvania, Inc.	: Pursuant to Sections 1401, 1402 and 1403 of : the Insurance Holding Companies Act, : Article XIV of the Insurance Companies Law : of 1921, Act of May 17, 1921, P.L. 682, <u>as</u> : <u>amended</u> , 40 P.S. §§ 991.1401 – 991.1403; : and Chapter 25 of Title 31 of The : Pennsylvania Code, 31 Pa. Code §§ 25.1 – : 25.23 : : Order No. ID-RC-18-14 : : :
--	---

**ORDER**

Upon consideration of the foregoing, the Insurance Commissioner of the Commonwealth of Pennsylvania ("Commissioner") makes the following Order:

The application of CVS Health Corporation (the "Applicant" or "CVS Health") to acquire control of Aetna Health Insurance Company, Aetna Better Health Inc., Aetna Health Inc., Health Assurance Pennsylvania, Inc., and Aetna Health Assurance Pennsylvania, Inc. (collectively, including any successor company, the "Domestic Insurers") through merger (the "Merger") of Hudson Merger Sub Corp., a wholly-owned subsidiary of CVS Health, with and into Aetna Inc. ("Aetna," and with the Domestic Insurers and CVS Health and its affiliates, the "CVS-Aetna Entities"), as set forth in the application, is hereby approved, subject to this Order, and the following conditions (collectively the "Conditions"):

1. The Applicant shall provide to the Pennsylvania Insurance Department ("Department") a list of closing documents within five (5) days after consummation of the subject transaction and shall maintain the listed documents and make them available to the Department for a period of not less than five (5) years from the date of consummation.

2. The Applicant shall develop, implement, monitor the operation of and enforce strict compliance with a firewall policy that is applicable to the Domestic Insurers. The firewall policy shall be in a form and substance acceptable to the Department. Within thirty (30) days after consummation of the subject transaction, the Applicant shall file with the Department, for


the review and approval of the Department, a comprehensive firewall policy that is applicable to the Domestic Insurers. The Applicant shall not make any material amendment, waive enforcement of or terminate any material provision of the approved firewall policy without the approval of the Department. Approved firewall policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the Applicant, to the extent that the Department believes that such review and/or examination is in the public interest.

3. CVS Health and its subsidiaries are prohibited from including a “most favored nation” provision, whether written or oral, in any agreement with any Pennsylvania licensed Aetna-affiliated health insurer, including any health maintenance organization or preferred provider organization.

4. The Applicant will cause the Domestic Insurers to report the information set forth on Attachment 1 attached hereto and incorporated herein in the manner and in accordance with the timing set forth therein.

5. The Department may retain at the expense of the Applicant, as determined by the Department, any attorneys, actuaries, accountants and other experts not otherwise part of the Department's staff as, in the judgment of the Department, may be necessary to assist the Department, whether retained before, on or after the date of this Order, in or with respect to: (i) evaluation and assessment of any reports, submissions or other information given or required to be given in connection with this Order; (ii) compliance by any of the CVS-Aetna Entities with this Order; and (iii) the enforcement, or any challenge or contest to enforcement or validity, of the Conditions or otherwise of this Order, including, but not limited to, reviewing and analyzing any reports, submissions or other information by or for any CVS-Aetna Entity or auditing and reviewing any books and records of any CVS-Aetna Entity to determine compliance with any of the Conditions. The obligations of the CVS-Aetna Entities to the Department for all such costs and expenses shall be joint and several obligations.

This Order is effective immediately and valid for one (1) year, provided no material changes are made to the transaction prior to consummation. This one-year limitation does not apply to any Conditions prescribed by the Department in this Order.

  
\_\_\_\_\_  
Jessica K. Altman  
Insurance Commissioner  
Commonwealth of Pennsylvania



**ATTACHMENT 1**  
**POLICYHOLDERS AND COMMUNITY BENEFIT REPORTING**

**TO**

**Approving Determination and Order**

In Re: Application of CVS Health Corporation for  
Approval of the Acquisition of Control of Aetna Inc., et al.

1. The following data shall be provided to the Department by Aetna (which for purposes hereof includes the Domestic Insurers) for the 2018 calendar year as a baseline, and then annually for calendar years 2019 through 2022. Aetna shall provide a report setting forth the data to the Department for the first six (6) months of 2018 within sixty (60) days after consummation of the subject transaction and for the full 2018 calendar year by February 15, 2019. Thereafter, Aetna shall provide the report setting forth the annual data to the Department no later than February 15<sup>th</sup> of each year for the preceding calendar year. The report shall be in form satisfactory to the Department.

(a) For Pennsylvania Aetna Enrollees (as hereinafter defined), separated by product category (commercial fully insured and Medicare):

- (i) Total number of Pennsylvania Aetna Enrollees
- (ii) Hospital stays and readmissions by Pennsylvania Aetna Enrollees
  - A. Avoidable 1 day hospital stays\*
  - B. Avoidable 2 day hospital stays
  - C. Hospital readmissions
- (iii) Number of emergency room visits by Pennsylvania Aetna Enrollees
- (iv) Number of visits to retail clinics and urgent care centers by Pennsylvania Aetna Enrollees
- (v) Infusions by Pennsylvania Aetna Enrollees
  - A. Number of infusions in hospital settings
  - B. Number of infusions in outpatient settings

---

\* This information, and all other information in Paragraph (a)(ii-vi) may be provided in actual numbers or on a per 1000 enrollee basis.

- (vi) Lab visits by Pennsylvania Aetna Enrollees
  - A. Number of lab visits
  - B. Number of lab visits to preferred providers

(b) For MinuteClinics:

- (i) Number of MinuteClinic visits by Aetna enrollees nationally (broken down among commercial fully insured and Medicare)
- (ii) Number of MinuteClinic visits by Pennsylvania Aetna Enrollees in (broken down among commercial fully insured and Medicare)
- (iii) Number of MinuteClinic visits nationally
- (iv) Number of MinuteClinic visits in Pennsylvania
- (v) Total number of MinuteClinics in Pennsylvania and nationwide

(c) For purposes hereof, "Pennsylvania Aetna Enrollees" means all persons that reside in the Commonwealth of Pennsylvania that are enrolled in any health benefit plan(s) maintained by the Domestic Insurers or any of their affiliates.

2. In addition, Aetna shall provide the Department with a detailed narrative annual report for the same years and filed by the same dates as provided above, on the implementation of cost savings and care improvement initiatives related to the Merger, including but not limited to those related to coordinated care initiatives, management of chronic conditions and prescription adherence management. The report shall detail the progress and status of the initiatives, including any pilot studies, as of the previous year end, and shall include a qualitative assessment of the efficacy of the initiative and the quantitative metrics Aetna uses to measure the success of the initiative and status of implementation, both nationally and, to the extent available, in Pennsylvania. Such data shall be provided separately for commercial fully insured and Medicare. The report shall also include the economic impact of each significant initiative, as tracked by Aetna in the ordinary course, both in terms of costs to Aetna and decreases in medical costs and benefits to Aetna's enrollees. If Pennsylvania-specific economics are collected by Aetna, they shall be included in the report. If not, Aetna shall extrapolate national data to provide an estimate of the economic benefits of the initiatives in Pennsylvania.