**CVS Health and the purchase of Aetna**

In December 2017, CVS Health Corporation announced the agreement to purchase Aetna Inc. for $69 billion combining the giant retail drugstore with one of the largest health insurance companies in the United States. Under the terms of the agreement, CVS would acquire all of the outstanding shares of Aetna financed through the use of cash and common stock. Each Aetna shareholder would receive .8378 shares of CVS Health and $145.00 per share in cash. Total valuation of Aetna is approximately $207 per share and CVS Health would assume all of Aetna’s liabilities. The total purchase price for the transaction is therefore approximately $77 billion although based on CVS Health’s stock valuation could move slightly up or down depending on the equity markets up until the closing date.1

The estimated closing date for the proposed acquisition is sometime during the second half of 2018, but will be subject to the approval of both company’s shareholders and board of directors. In addition, the transaction will have to wait for the expiration of the waiting period under the federal Hart-Scott-Rodino Antitrust Improvements Act of 1976 or the HSR Act to provide ample time for regulators to review the acquisition. In addition to federal regulatory approval, such as from the Department of Justice (DOJ) and Federal Trade Commission (FTC), the transaction will also need the blessing of state departments of insurance and also international regulators.

The merger, the largest of the year, would reshape how we look at health care by combining two entities within an industry that have traditionally been kept apart. It is thought that the deal would be more appealing to consumers as health care that was once delivered in a physician’s office has moved to a simple phone call, retail clinic or outlet, or through an app.2

The transaction also comes at a great sign of uncertainty and risk in the health care market. Under the present Congress and White House, health care has been under attack with provisions under the Affordable Care Act eliminated and the budget for Medicare with the approved tax cuts uncertain. Adding to the uncertainty, companies and employees are struggling under the growing cost of health insurance and medical costs combined with an escalating rise in the price of prescription drugs.

Although unclear, raising questions of how the market may end up looking is Amazon and their rumored interest into entering the health care industry, specifically the pharmaceutical business, utilizing its rapidly advancing technology.

The combination of the two companies would create a patient flow that includes pharmacies, retail clinics, and a health insurance company. The new company. Employers could benefit from this model that resembles a “one-stop shop”

1 CVS Health Corporation. United States Securities and Exchange Commission. Annual Report. Form 10K. December 31, 2017 2 De la Merced, M. and Abelson, R. “CVS to Buy Aetna for $69 Billion in a Deal that may Reshape the Health Industry.” The New York Times December 3, 2017

1

approach to health care. The outpatient model is considered one that would also reduce expenditures and more affordable to the system.

As part of the announcement, both companies outlined a plan that would transform CVS’s 10,000 pharmacy and clinical locations into “community based” clinics that delivered care with technology and a health data system. Patients could conceivably visit a clinic for the flu, but also be monitored for hypertension, diabetes, or chronic heart disease.

This deal is a bit unusual than the traditional merger between two similar companies. Horizontal transactions, while they can be highly scrutinized by regulators for potential antitrust violations, if successful will yield significant expenditure reductions through synergies and economies of scale. Vertical transactions such as a CVS\Aetna marriage will result in fewer reductions in expenditures and perhaps increase the costs of competing insurance companies that wish to access CVS’s large number of pharmacies and clinics. If likely approved, further acquisitions between additional similar pharmaceutical chains and large health insurance companies. In fact, just a few months following the announcement of this transaction, Walmart expressed an interest in the purchase of Humana.

Regardless, the shareholders approved the merger by a 98% margin that would combine the service of pharmacists, health care providers, and insurance companies. The argument is that it will benefit both patients, shareholders, and insurance companies obviously concerned about cost. This comes at a time whereby “Amazon, Berkshire Hathaway and JPMorgan announced in January that they’re working together to create a new health care venture for their own staff aimed at improving employee satisfaction and reducing costs.3

**Governmental Possible Concerns**

Under normal circumstances, this vertical transaction would fly through the approval process. Unfortunately, we’re not there yet because of the size of these two companies. These are two large corporations that have a significant ownership of their respective market.

Okay... Strange...The Trump administration is not ready to sign off on this merger despite a campaign of business friendly verbal rhetorical speeches. What was thought to be a business-friendly environment has turned out to be one of skeptical observance. This, is actually a good thing. All mergers during the Hart Scott Rodino Filing should be analyzed and tested for potential industry influence. This transaction is very complicated and should be on the front burner despite the vertical nature of the deal. This transaction could very well impact the entire health care market despite its vertical nature. The question is whether or not the vertical transaction would impact the market. Despite the underwhelming concerns over the

3 Weixel, N. “Shareholders overwhelmingly approve CVS-Aetna merger.” The Hill March 13, 2018

2

**CVS Health Corporation4**

CVS Health sees itself as a pharmacy innovative company assisting people continue their path to healthy lives. It has a wide variety of models and structures that assist in this pursuit changing the landscape of how health care is operated delivering higher clinical outcomes, efficiency, and all at a lower cost.

Through almost 10,000 retail store locations, approximately 1,100 walk-in health care clinics, a 94 million member pharmacy benefits manager, and the leading stand-alone Medicare Part D prescription plan, the company enables patients and businesses to make health care less expensive and more efficient. The company provides patients medical advice on their medications through CVS Pharmacy and reduces costs for patients that participate through the online prescription drug programs offered through CVS Caremark as well as improving care for patients with complex health conditions through CVS Specialty and the senior community under Omnicare.

**CVS Pharmacy**

The Pharmacy Services Segment provides a wide array of services, or pharmacy benefit management (PBM) to insurance companies, employers, government groups, health plans, Medicare and Medicaid plans, plans offered on the public and private exchanges, and individual plans. Under the SilverScrip Insurance Company subsidiary, drug benefits are provided to those eligible for Medicare’s Part D program.

Through almost 36,000 pharmacists, nurses, nurse practitioners and physician assistants, customers and patients are served through multiple touch points such as retail outlets, mail order, infusion, long-term care and specialty pharmacies, retail clinics, digital resources, and cost management tools, the company strives to provide access to health care at almost all points of service.

Other services within the PBM include:

*Plan Design Offerings and Administration* – CVS administers pharmacy benefit plans for clients who contract the company to provide prescription coverage and claims processing for their eligible plan members.

*Formulary Management* – The company utilizes an independent panel of doctors, pharmacists and other medical experts to sit on the CVS Caremark National Pharmacy and Therapeutics Committee to review and approve the selection of drugs to ensure their safety and efficacy to be offered at their pharmacies and mail order businesses. Recommended drugs, via classification, along with options or alternatives provide the best information on cost and clinical benefits to the patient.

4 All information about CVS Health Corporation was taken from the December, 31 2017 Annual Report Form 10K

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*Medicare Part D Services* – The company is a participant in the administration of the drug benefit added to the Medicare program, Part D. The company assists employers, unions or other health plans that qualify for the retiree drug subsidiary.

*Mail Order Pharmacy* – As of the end of 2017, CVS Health operated four mail order distribution center pharmacies in the United States. Drug requests via mail or internet, usually for consistent filling, are reviewed by a pharmacist before being sent.

*Specialty Pharmacy* – Through 18 specialty mail order centers, the company supports patients with more complex and expensive drug regimes. In addition, CVS operates 23 retail specialty stores that serves the same group of patients suffering from chronic or genetic disorders.

*Retail Pharmacy Network Management* – CVS maintains a national network of more than 68,000 including 41,000 pharmacy chains and 27,000 independent pharmacies. This allows patients to fill a prescription at multiple locations.

*Prescription Management Systems* – All prescription drugs processed through this system allows the company to manage early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization, or potential fraud.

*Clinical Services* – CVS offers multiple clinical programs to clients to manage overall drug and health care costs while promoting quality outcomes.

*Disease Management Programs* – This service is designed to assist in the management of rare complex conditions such as multiple sclerosis, seizures, and rheumatoid arthritis.

*Medical Benefit Management* – This is technology platform, NovoLogix, an online preauthorization software package, is designed to capture cost savings for specialty drugs checking dosages and costs, as well as whether or not it is clinically appropriate.

**Retail LTC**

At the end of 2017, CVS Health operated 9,803 retail locations with 1,695 were pharmacies operated within Target Corporation stores. The company also owned online retail pharmacy websites, CVS.com, Navarro.com, and Onofre.com.br, 37 onsite pharmacy stores, as well as long-term care pharmacy operations and retail health clinics. The retail locations are in 49 states, the District of Columbia, Puerto Rico, and Brazil. Store size varies between 5,000 to 30,000 square feet although most new stores are approximately 11,000 to 15,000 square feet.

**Corporate**

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The Corporate area provides management and administrative support to each of the segments of the company including executive management, finance, legal, human resources, information technology, and procurement.

**Funding CVS**

Working capital to fund the growth of the business is generated using cash flow from operations, commercial paper, lines of credit, and long-term borrowing for more capital intensive projects.

**Aetna, Inc.**

Aetna is one of the largest diversified health care benefits companies with approximately 46.7 million subscribers. The company offers a wide range of health care insurance products including medial, pharmacy, dental, behavioral health, group life and disability plans, medical management, Medicaid health care management, Medicare Advantage and Medicare Supplement plans, workers’ compensation administrative services, and health information technology products and services. Customers of Aetna include employer groups, individuals, college students, part-time and hourly workers, health care providers, governmental units, government-sponsored plans, labor groups, and expatriates.

**Aetna’s Failed Merger with Humana**

Aetna has had some recent setbacks with the termination of the acquisition of Humana Inc. In 2015, Aetna entered into a definitive agreement to acquire Humana in a transaction valued at approximately $37 billion based on Aetna’s stock closing price on July 2, 2015. In the deal, Aetna would retain all of Humana’s cash, other current assets, and assume all of Humana’s debt.

Before the acquisition could be completed, the United States Department of Justice and a few state attorney generals filed a civil complaint in the U.S. District Court for the District of Columbia against Aetna and Humana charging that the transaction would violate Section 7 of the Clayton Antitrust Act. The government sought an injunction to prevent the deal from moving forward. By February 2017, the transaction was virtually dead and Aetna and Humana entered into a mutual termination agreement. Under the agreement, Aetna would compensate Humana the Regulatory Termination Fee of $1.0 billion in cash as required under the original Merger Agreement. In addition, both parties would release each other from any and all liability, claims, rights, actions, causes of actions, suits, liens, obligations, accounts, debts, demands, agreements, promises, controversies, costs, charges, damages, expenses and fees, however likely or unlikely, in connection with the termination of the merger.5

5 Aetna, Inc. United States Securities and Exchange Commission. Form 10-K Annual Report. December 31, 2016, p. 4

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The fee paid to Humana was funded through an issue of senior notes that were part of the overall acquisition. In June 2016, Aetna floated $13 billion in senior notes of which most would fund the acquisition. With the acquisition terminated, the amount of cash and debt was no longer required. In accordance with the terms of the issued notes, Aetna called $10.2 billion in principal with a redemption price of 101% (principal and interest). The cost of this payment in principal and interest was approximately $100 million and was absorbed in the first quarter of 2017.

During the acquisition and arising from the Department of Justice’s concerns regarding Aetna’s Medicare Advantage as a result of the Humana combination, Aetna entered into a definitive agreement to sell for cash to Molina Healthcare, Inc. a portion of the company’s Medicare Advantage assets. The thought was a reduction in this area of the company’s business would allow the merger to be completed. With the acquisition terminated, there was no need to divest these assets. In February 2017, Aetna entered into a termination agreement with Molina and paid the company $53 million or approximately 70% of Molina’s acquisition expenses. The cash to pay Molina was also funded through the proceeds from the 2016 senior notes. As with the termination expense from the abandoned deal with Humana, this expense was absorbed in the first quarter of 2017.

**Health Care Reform**

For the past decade, major changes have come to the U.S. health care system. Prior to 2010, health insurance was either acquired through an individual purchase, corporate or employer based coverage, private payment for services, government coverage through either Medicare or Medicaid, or individuals went without insurance and took their chances. Individuals without insurance, if injured, would require care through an emergency room where legally providers must treat and stabilize a patient before discharge. Since these individuals rarely possessed enough funds to pay for the treatment, the cost of their emergency room visit would be shifted to those with employer sponsored insurance.

The long result of this insurance structure led to a rapidly growing cost for commercial health care premiums. In an attempt to slow the increase in the cost of health care, the government passed The Patient Protection and Affordable Care Act and Education Reconciliation Act of 2010 (ACA). Under the provisions of the ACA, all Americans would be required to have health insurance or pay a penalty. This is a similar model to a system that was implemented in Massachusetts under Governor Romney in 2006. To help with coverage, some states such as Ohio, expanded Medicaid coverage to reduce the number of people needing to purchase their own health insurance.

The new law was not necessarily good for insurance companies as one might assume. With the expansion of coverage, programs such as Medicare Advantage reduced what they paid insurance companies to manage their respective participants putting pressure on profitability.

The purchase of health insurance was a major component of the ACA with the government establishing public health insurance exchanges where people could shop

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for the insurance they felt met their needs. This system was phased in during 2014 with additional provisions of the law being implemented slowly through 2020.

While the ACA moved the United States health care system towards something similar, but not quite equal, to a country such as the United Kingdom with universal coverage with the option to use commercial insurance, it was met by strong opposition in certain areas of America. The Republican party continually attempted to repeal the act sending multiple bills to President Obama only to receive multiple vetos.

However, in 2017, under a new administration, the tides turned and an opportunity with Republicans controlling the Executive Branch and both houses of Congress. The first real attempt to repeal the law failed with Senator McCain (R- Arizona) voting against sending the bill to the White House for approval. Months later, the Senate approved and passed the Tax Cuts and Jobs Act of 2017 that was later signed by the President. While it was mostly a bill targeting a revision in the tax code, the bill also removed the mandate under the ACA for all persons under the age of 65 to have health care coverage starting in 2019. Fewer people with health insurance, as stated by the Congressional Budget Office (CBO), could lead to savings of $300 billion further supporting the increased size in tax cuts primarily for corporations and wealthy families. The insurance impact could be 13 million losing their health care coverage by 2025 including 5 million without their Medicaid coverage.

Changes to the health care system seem to be far from over and may happen in the near future. With a potential swing in the November 2018 elections, Democrats may take back the House of Representatives creating a difficult environment for any continued adverse change to coverage. The President’s approval ratings are also extremely low and with an election in 2020, power may shift again creating an opportunity to bring back a form of the mandate.

All said, the United States health care system is in a state of flux with no apparent model or proposal solidifying a direction the country should go in. From a business planning and strategy perspective, not just health care insurance companies, but medical device companies, bio technology firms, pharmaceutical companies, hospitals, outpatient clinics and support firms, lab testing services, academic research universities and institutions, state and local municipalities, and patients all have a high degree of uncertainty creating a situation whereby any type of investment in the future carries with it an increased amount of risk.

A company such as Aetna will weather a health care storm although it may need to change to survive and thrive in a new industry environment. Other smaller and less diverse organizations may not survive with further significant changes to health care coverage.

**Competition in Health Insurance**

The health care benefits industry is extremely competitive with a large number of for-profit and not-for-profit competitors in the field. The market is mostly regional

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although there are several national players that also compete on a local level. The industry is also extremely price sensitive with many individuals choosing a health care plan over another for just a few dollars difference per pay period. Others may choose to pay a little more, but only if they have access to their physician’s practice and hospital system and others will select a plan with a concern over particular coverage for a specific illness or treatment.

**Conclusion**

The potential acquisition between these two firms is interesting. In a way, it’s difficult to ascertain the type of acquisition this is. It certainly isn’t horizontal, but could be considered both vertical and conglomerate. Vertical because Aetna patients would be driven to use CVS pharmacies, but conglomerate because the pharmacy component of Aetna is negligible. So, at the end of the day, is this really a good acquisition for CVS shareholders or is it just a defensive measure against the possible competition coming from companies such as Amazon that have suggested a potential entry into this market?

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Exhibit 1

**CVS Stock Values** Q1 Q2 Q3 Q4 Year

2017 High $ 83.92 $ 82.79 $ 83.31 $ 80.91 $ 82.79

Low $ 74.80 $ 75.95 $ 75.35 $ 66.80 $ 66.80

Cash dividends per common share $ 0.50 $ 0.50 $ 0.50 $ 0.50 $ 2.00

2016 High $ 104.05 $ 106.10 $ 98.06 $ 88.80 $ 106.10

Low $ 89.65 $ 93.21 $ 88.99 $ 73.53 $ 73.53

Cash dividends per common share $ 0.425 $ 0.425 $ 0.425 $ 0.425 $ 1.70

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Exhibit 2

**CVS Balance Sheet**

YEAR ENDED DECEMBER 31,

IN MILLIONS, EXCEPT PER SHARE AMOUNTS 2016 2015

Assets:

Cash and cash equivalents **$ 3,371** $ 2,459

Short-term investments **87** 88

Accounts receivable, net **12,164** 11,888

Inventories **14,760** 14,001

Other current assets **660** 722

Total current assets **31,042** 29,158

Property and equipment, net **10,175** 9,855

Goodwill **38,249** 38,106

Intangible assets, net **13,511** 13,878

Other assets **1,485** 1,440

Total non-current assets **63,420** 63,279

Total assets **$ 94,462** $ 92,437

Liabilities:

Accounts payable **$ 7,946** $ 7,490

Claims and discounts payable **9,451** 7,653

Accrued expenses **6,937** 6,829

Short-term debt **1,874** -

Current portion of long-term debt **42** 1,197

Total current liabilities **26,250** 23,169

Long-term debt **25,615** 26,267

Deferred income taxes **4,214** 4,217

Other long-term liabilities **1,529** 1,542

Commitments and contingencies **-** -

Redeemable noncontrolling interest **-** 39

Total long-term liabilities **31,358** 32,065

Total liabilities **$ 57,608** $ 55,234

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Exhibit 3

**CVS Income Statements**

YEAR ENDED DECEMBER 31,

IN MILLIONS, EXCEPT PER SHARE AMOUNTS 2016 2015

Net revenues **$ 177,526** $ 153,290

Cost of revenues **148,669** 126,762

Gross profit **28,857** 26,528

Operating expenses **18,519** 17,074

Operating profit **10,338** 9,454

Interest expense, net **1,058** 838

Loss on early extinguishment of debt **643** -

Income before income tax provision **8,637** 8,616

Income tax provision **3,317** 3,386

Income from continuing operations **5,320** 5,230

Income(loss) from discontinued operations **(1)** 9

Net income **$ 5,319** $ 5,239

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Exhibit 4

**CVS Stores**

2016 2015

Total Stores (beginning of year) **9,665** 7,866

New and acquired stores **132** 1,833

Closed stores **(47)** (34)

Total stores (end of year) **9,750** 9,665

Relocated stores **50** 58

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Exhibit 5

**Aetna Stock Valuation**

High Low

**2016**

Q1 **$ 144.19 $ 94.31**

Q2 **122.72 107.90**

Q3 **121.04 112.81**

Q4 **134.90 105.20**

**2015**

Q1 $ 109.26 $ 87.60

Q2 132.60 106.08

Q3 128.90 105.30

Q4 115.34 99.89

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Exhibit 6

**Aetna Balance Sheet**

DECEMBER 31,

(millions) 2016 2015

Assets:

Cash and cash equivalents **$ 17,996** $ 2,524

Investments **3,046** 3,015

Premiums receivable, net **2,356** 1,880

Other receivables, net **2,224** 2,307

Accrued investment income **232** 228

Income taxes receivable **44** 261

Other current assets **2,551** 2,510

Total current assets **28,449** 12,725

Long-term investments **21,833** 21,665

Reinsurance recoverables **727** 724

Goodwill **10,637** 10,637

Other acquired intangible assets, net **1,442** 1,688

Property and equipment, net **587** 630

Other long-term assets **1,480** 1,405

Separate Accounts assets **3,991** 4,035

Total non-current assets **40,697** 40,784

Total assets **$ 69,146** $ 53,509

Liabilities:

Health care costs payable **$ 6,558** $ 6,306

Future policy benefits **645** 672

Unpaid claims **801** 772

Unearned premiums **556** 676

Policyholder's funds **2,772** 2,263

Current portion of long-term debt **1,634** -

Accrued expenses and other current liabilities **5,728** 4,920

Total current liabilities **18,694** 15,609

Future policy benefits **5,929** 6,268

Unpaid claims **1,703** 1,656

Policyholder's funds **812** 886

Long-term debt, less current portion **19,027** 7,785

Deferred income taxes **4** 177

Other long-term liabilities **1,043** 914

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Separate Accounts liabilities **3,991** 4,035

Total long-term liabilities **32,509** 21,721

Total liabilities **$ 51,203** $ 37,330

Exhibit 7

**Aetna Income Statement**

YEAR ENDED DECEMBER 31,

IN MILLIONS, EXCEPT PER SHARE AMOUNTS 2016 2015

Revenue:

Health care premiums **$ 54,116** $ 51,618

Other premiums **2,182** 2,171

Fees and other revenue **5,861** 5,696

Net investment income **910** 917

Net realized capital gains (losses) **86** (65)

Total revunue **63,155** 60,337

Benefits and expenses

Health care costs **44,255** 41,712

Current and future benefits **2,101** 2,121

Operating expenses:

Selling expenses **1,678** 1,611

G&A **10,407** 10,033

Total operating expenses **12,085** 11,644

Interest expense **604** 369

Amortization **247** 255

Reduction **(128)** -

Total benefits and expenses **59,164** 56,101

Income before income taxes **3,991** 4,236

Income tax expenses **1,735** 1,841

Net income **$ 2,256** $ 2,395

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