Exhibit 16

Competitive Impact Analysis of the Transaction in the State of Connecticut.

ACQUISITION BY CVS HEALTH CORP. OF AETNA INC.

Connecticut Competition Analysis

CVS Health Corporation ("CVS Health") proposes to acquire Aetna Inc. ("Aetna"). Together, CVS Health and Aetna will build a health care platform based on the principles of greater convenience and lower cost while offering consumers the ability to interact with health care experts they know and trust in communities all across the country. By combining the expertise and analytics of Aetna with CVS Health's local presence and clinical capabilities, the combined company will become the front door to health care, delivering care whenever, wherever, and however it is needed.

CVS Health's proposed acquisition of Aetna will neither reduce substantially competition in any line of business nor tend to create a monopoly in Connecticut.[1] Rather, the transaction will deliver substantial public benefits such as improved health outcomes and lower health care spending by consumers in Connecticut and throughout the United States. By advancing the quality of care and increasing efficiency, the combined company will compete more effectively in what is already a highly competitive space, with many different competitors offering dozens of insurance products across multiple lines of insurance.

A. The Transaction Will Not Increase Concentration in Any Reported Line of Business in Connecticut

Conn. Gen. Stat. § 38a-131(d)(2) requires that the parties to the transaction report to the Commissioner "direct written insurance premium for a line of business, such line being that used in the annual statement insurance companies doing business in this state are required to file with the commissioner." For the business lines defined by the National Association of Insurance Commissioners ("NAIC") and reported in CVS Health's and Aetna's annual statements, there is no competitive overlap in Connecticut. The transaction will not result in any increase in share or concentration in any reported line of business. Accordingly, the proposed transaction qualifies for exemption under the standards established by Conn. Gen. Stat. § 38a-131(b)(4)(A)-(C).

Attached as Exhibit X is a chart setting forth direct 2012-16 written premiums and share for CVS and Aetna for the relevant lines of business in Connecticut reported to the NAIC on the Life and A&H and the Health Only blanks. The data was obtained from SNL Financial, which sources the data from the NAIC. Exemptions are determined by reference to 2016 premiums, the most recent full-year data that is available.

1. Life and A&H

Medicare Title XVIII Exempt from State Taxes: No share increase. CVS Health does not issue coverage reported under Medicare Title XVIII Exempt from State Taxes in Connecticut. Exempt under Conn. Gen. Stat. § 38a-131(b)(4)(B).

[1] *See* Conn. Gen. Stat. § 38a-131(d)(1) ("For a proposed acquisition not exempt under subsection (b) of this section, the commissioner shall evaluate whether such proposed acquisition will reduce substantially competition in any line of insurance business in this state or tend to create a monopoly in this state.").

2. Health Only

Other Health: No share increase. Aetna does not issue coverage reported under Other in Connecticut. Exempt under Conn. Gen. Stat. § 38a-131(b)(4)(B).

Medicare Supplement: No share increase. Aetna does not issue coverage reported under Medicare Supplement in Connecticut. Exempt under Conn. Gen. Stat. § 38a-131(b)(4)(B).

Title XVIII Medicare: No share increase. CVS Health does not issue coverage reported under Title XVIII Medicare in Connecticut. Exempt under Conn. Gen. Stat. § 38a-131(b)(4)(B).

B. The Transaction Will Not Reduce Substantially Competition or Tend to Create a Monopoly in Medicare Part D Prescription Drug Plans Offered in Connecticut

Notwithstanding the NAIC-defined line-of-business exemptions discussed above, there is some competitive overlap in the area of Medicare Part D prescription drug plans, where CVS Health and Aetna compete with many other companies for Medicare beneficiaries, both nationally and in Connecticut.

However, the proposed transaction will not substantially reduce competition in the Part D area. The combined company will continue to face vigorous competition in Connecticut, where in 2018 Medicare beneficiaries can choose from 22 standalone Part D plans offered by nine different companies. Comprehensive regulations issued by the Center for Medicare and Medicaid Services ("CMS") encourage Part D plan sponsors to compete aggressively for Medicare beneficiaries on numerous price and non-price dimensions. Experience also shows that, with no significant barriers to entry or expansion, Part D competitors can expand and new firms can enter the marketplace. Finally, the proposed transaction will result in substantial benefits to consumers and the overall health care system. As a result, the proposed transaction will not reduce substantially competition or tend to create a monopoly in Medicare Part D drug plans.

1. Medicare Beneficiaries Will Continue to Have Many Part D Options Following the Transaction

Both nationally and in Connecticut, consumers have numerous Part D options. The companies face intense competition from several large competitors that sell both standalone Part D plans and Medicare Advantage prescription drug plans, such as UnitedHealth, Humana, Cigna, and Anthem. The companies also face competition from companies that, similar to CVS Health, sell only standalone Part D plans but not Medicare Advantage plans, such as Express Scripts and Rite Aid. There are also many formidable regional competitors.

For 2018, CMS's Medicare Plan Finder website shows that Connecticut Medicare beneficiaries seeking standalone Part D coverage can choose from 22 plans offered by nine different companies:

Standalone Part D Plans Offered in Connecticut for 2018

Company	# of Plans	Plan Name
Aetna	3	• Aetna Medicare Rx Select • Aetna Medicare Rx Saver • First Health Part D Value Plus
Anthem	2	• Blue MedicareRx Value Plus • Blue MedicareRx Premier
CIGNA	2	• Cigna-HealthSpring Rx Secure • Cigna-HealthSpring Rx Secure-Extra
CVS Health	2	• SilverScript Choice • SilverScript Plus
Express Scripts	3	• Express Scripts Medicare - Saver • Express Scripts Medicare - Value • Express Scripts Medicare - Choice
Humana	3	• Humana Walmart Rx Plan • Humana Preferred Rx Plan • Humana Enhanced
Rite Aid	1	• EnvisionRxPlus
UnitedHealthcare	4	• AARP MedicareRx Walgreens • AARP MedicareRx Saver Plus • AARP MedicareRx Preferred • Symphonix Value Rx
WellCare	2	• WellCare Classic • WellCare Extra

These nine active Part D competitors in Connecticut consist of some of the largest, most capable health care companies in the country. Few markets have this many large, sophisticated, multi-billion dollar companies already very active in aggressively promoting their products in Connecticut.

Enrollment data from CMS also show the large number of Part D options available to Connecticut consumers. In addition to CVS Health, which has a 30.1% share of enrollees, and Aetna, which is the fifth-largest standalone PDP provider in Connecticut with a 7.6% enrollee share, significant competitors include UnitedHealthcare (27.0%), Humana (12.4%), Express Scripts (11.3%), and WellCare (4.8%). Over the past five years, Express Scripts has increased its share from 2.7% to 11.3%, becoming the fourth-largest standalone Part D provider, while Aetna's share has dropped from 10.6% to 7.6%.

These enrollment-based shares likely overstate the competitive significance of the combined company and understate the significance of other competitors. First, enrollment-based shares likely overstate the combined company's competitive significance because CVS Health focuses on lower-revenue Part D plans. Based on CMS premium data, the combined company's share of Connecticut standalone Part D plans is 35.1% (compared to 37.7% based on enrollment).

Second, current enrollment shares understate the competitive importance of Cigna going forward. Cigna was sanctioned by CMS in January 2016, which prevented it from marketing its standalone Part D and Medicare Advantage plans. CMS lifted these sanctions in July 2017. In December 2015, prior to the sanctions, Cigna's national Part D membership exceeded Aetna's. As it returns from sanctions, Cigna is likely to grow. As a senior Cigna executive announced, Cigna is a "better and stronger company as a result of collaborating with CMS and investing in [its] processes and technology" while under sanctions.[2]

Third, enrollment shares are backward-looking and can shift up or down by significant percentages each year given the dynamic nature of the marketplace in which beneficiaries have an opportunity annually to switch to a more attractive plan. This year's distribution of enrollment may not be an accurate predictor of next year's enrollment shares.

Fourth, standalone Part D enrollment shares do not account for the significant competition that standalone Part D plans face from Medicare Advantage Part D plans. Competition is fierce to attract the thousands of seniors that age into Medicare each day, as beneficiaries are increasingly choosing comprehensive Medicare Advantage plans over standalone Part D plans. Overall, about 40% of seniors with Part D coverage are enrolled in Medicare Advantage plans – a percentage that has grown over the past several years and is expected to continue to grow.

2. CMS Facilitates Aggressive Competition among Plan D Sponsors

Comprehensive CMS regulations governing the Part D program ensure that plan sponsors must compete aggressively on both price and non-price dimensions for Medicare beneficiaries. The Part D regulatory framework places significant constraints on plan sponsor pricing decisions that are not present in less regulated markets.

The CMS bidding process fosters significant price competition among standalone Part D plan sponsors, which face significant pressure to submit low-cost and high-quality bids. Reflecting the large number of bidders seeking to offer Part D plans, there are an average of 23 PDP plans per CMS region for 2018.

Plan D sponsors have substantial economic incentive to achieve and maintain a high star rating from CMS, which allows plans earning a five-star rating to market and enroll new beneficiaries year-round, not just during the annual open enrollment period. Conversely, CMS has the authority to remove from the Part D program plans that have fewer than three stars for three consecutive years.

CMS further facilitates competition by ensuring that Medicare beneficiaries have access to and can easily compare information about Part D plans. The cost, benefit design, drug formulary, and pharmacy networks offered by each competing Part D plan, as well as its quality rating and other pertinent information, are fully transparent to beneficiaries through the detailed plan

[2] CMS Lifts Medicare Advantage Sanctions on Cigna, Modern Healthcare, June 16, 2017, http://www.modernhealthcare.com/article/20170616/NEWS/170619911.

information available on the Medicare Plan Finder website. Consumers dissatisfied with their plan can easily switch plans at annual open enrollment periods.

CMS retrospectively regulates margins on Part D plans, requiring that at least 85% of premium revenue must be spent on the provision of health care, while only 15% of revenue may go to administrative costs and profit. CMS evaluates bids prospectively to compare benefit value with expected margin.

Taken together, CMS regulations create powerful incentives for Part D plan sponsors to compete, resulting in a vibrant, dynamic space in which Part D plan sponsors must offer competitively-priced, high-value plans to Medicare beneficiaries.

3. Experience Shows that Part D Competitors Can Expand and New Firms Can Enter Part D

There has been significant entry and expansion by firms offering Medicare Part D plans, as evidenced by the presence of more than 40 standalone Part D plan competitors across the country. There are eight standalone Part D plan sponsors currently operating in all 34 CMS regions covering the 50 states and the District of Columbia. Connecticut residents may choose from among 22 standalone Part D plans offered by nine different competitors.

Not only is there a lack of meaningful entry barriers in Part D, there are CMS regulations that help plans expand into new regions. For example, CMS may waive the state licensure requirement for up to three years if the Part D sponsor seeks to expand into a state in which it does not currently have a license. This waiver makes expansion easier and timelier, as it allows the plan sponsor to enter a new state without having to wait to complete the licensure process.

Entry and expansion in Part D is further facilitated by the ease with which seniors can switch plans from year to year. During each open enrollment period, Medicare beneficiaries can use the Plan Finder website to compare plans, including both standalone Part D and Medicare Advantage plans. If a senior views a particular plan as non-competitive on price, quality, or any other metric, the senior can switch to another plan with more desirable attributes. Switching between standalone Part D plans can and does happen, as does switching between standalone Part D and Medicare Advantage plans. Beneficiaries can switch plans each year without any charges.

Ease of expansion is also demonstrated by the presence of a number of Part D competitors that have been able to rapidly increase their enrollment in a short time frame. For example, between 2013 and 2017, Humana grew its enrollment in standalone Part D plans by 60% on a national basis, while WellCare grew over 20% and Express Scripts grew 16%. In Connecticut, Express Scripts nearly tripled its share between 2013 and 2017.

Given these entry and expansion dynamics, as well as the rapidly growing Medicare-eligible population, the companies expect Part D competition to continue to increase post-merger.

4. The Transaction Will Generate Substantial Benefits to Connecticut Consumers and the Overall Health Care System

The proposed transaction will enhance patient care while generating substantial cost savings and quality improvements for consumers in several ways.

First, by integrating the companies' pharmacy data and medical claims data, the combined company will develop a more complete picture of a patient's health, which is otherwise rarely available in today's health care system. The combined company will have superior data and predictive analytics capabilities to improve the quality and coordination of care across multiple touchpoints.

Second, the combined company will allow patients to access high-quality care in more convenient and affordable locations by extending localized care to communities throughout the country. Patients will have access to a wide range of different care sites, including more than 9,700 CVS Health pharmacies and 1,100 MinuteClinics, as well as to more than 30,000 nurses and skilled care professionals employed by CVS Health. Using CVS Health's local presence and Aetna's deep collaborations with physicians and hospitals, the combined company will enhance access to more convenient sites of care.

Third, the combination of the companies' complementary assets will generate significant savings by improving the continuity of care patients receive and by providing such care at the lowest cost, clinically tailored site of care. Aetna manages a robust network of medical benefit providers, while CVS Health has a broad portfolio of pharmacy services. But there is currently insufficient coordination of care across providers. The combined company will bridge gaps in care and ensure treatment at the best site of care. For example, the combined company will reduce emergency room visits by making walk-in clinics available for the treatment of common, low-acuity conditions when appropriate, and by relying on experienced pharmacists to improve medication and treatment adherence, further reducing hospital admissions.

Fourth, the combined company will pursue many opportunities to contain costs in ways that will benefit consumers. Through Aetna's medical benefits plans and Caremark's pharmacy benefits plans, the combined company will manage billions of dollars in annual health care spending. Applying the most advanced value-based reimbursement systems and best-in-class purchasing across its portfolio, the combined company will accelerate cost reductions and incentivize value-based care.

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By combining the medical expertise and analytics of Aetna with CVS Health's strong local presence and clinical capabilities, the combined company will become the front door to health care, delivering lower-cost care, wherever it is needed. The proposed transaction will bring pharmacy and medical data integration, better use of localized care, continuity of care across providers, and significant cost containment, all of which will raise the level of care patients receive. Because the combined company will deliver more value and better health outcomes than CVS Health and Aetna would operating independently, the proposed transaction is in the public interest and should be approved.