The CVS-Caremark Merger
And The Coming Preferred Provider War

By
Lawrence W. Abrams, Ph.D.
12/29/06

Abstract

A disaggregation of CVS's income statement for the last six years is presented to support the contention that there is a significant disparity in operating income of CVS's pharmacy business versus the rest of its business known as the front store.

We contend that CVS has sought out this merger in order to motivate Caremark to name CVS as its exclusive retail preferred provider. This would help CVS weather a new era of price competition by generating greater traffic without store expansion to offset lower margins on retail prescriptions.

By comparing state maps of drugstore concentration with maps of the dominant healthcare plan by state, it is possible to derive a number of insights into the coming drugstore preferred provider war:

(1) The pairing of CVS and Caremark makes sense, but the merger seems defensive rather than designed to expand CVS's share in swing states.

(2) Rite-Aid will be the biggest loser of market share. Second will be supermarket pharmacies. Community pharmacies are still needed to satisfy coverage requirements and will not lose market share.

(3) Walgreen does not need to partner with any of the Big 3 PBMs to win the coming preferred provider war.

(4) WellPoint is the single most important strategic partner of the war.

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Disclosures:

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I have a Ph.D. in Economics from Washington University in St. Louis and a B.A. in Economics from Amherst College. Other papers on drugstores and PBMs can be accessed at www.nu-retail.com

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Two Proposals to Merge with Caremark

CVS, one of the two largest drugstore chains in the United States, announced on November 1, 2006 that it was merging with Caremark Rx, one of the three largest pharmacy benefit managers (PBMs). The proposed merger would be a "game-changer". It could not be easily classified as vertical merger or horizontal merger because Caremark is both a buyer of CVS prescriptions and a competitor of CVS via its captive mail order operations.

We believe that this merger is decidedly pro-competitive. It is a sign that CVS is accepting a future of price competition, but working to make it more "elastic" by motivating Caremark to steer more traffic its way in return for reduced prescription prices.

Express Scripts, the third largest PBM, announced on December 16, 2006 a competing bid for Caremark. The Express Scripts-Caremark combination clearly would be a horizontal merger. Express Scripts claims that merger is pro-competitive as it is designed to increase purchasing power with brand and generic drug manufacturers.

The merger of two of the Big 3 PBM "middlemen" would be competitive if the combined company acted as a "countervailing power" as envisioned by economist John Kenneth Galbraith. While it is possible that such a large reseller could be countervailing and pro-competitive, Wal-Mart comes to mind, we believe that this particular merger would be anti-competitive. Following the economist George Stigler, we are skeptical here of the applicability of Galbraith's belief that an

intermediate market countervailing power would behave asymmetrically – a powerful buy-side opponent to up-steam oligopolists, but a benevolent sell-side friend to down-stream consumers.

Wall Street also believes that the Express Scripts-Caremark merger would be anti-competitive, and profit-enhancing to the drug supply chain, as evidenced by upward movement in stock prices of Medco Health Solutions, Walgreen, and Rite-Aid. The opposite was the case a month earlier when the CVS-Caremark merger was announced, suggesting that Wall Street also concurred with our assessment that this merger would be pro-competitive, and profit-diminishing to the drug supply chain, on balance.

Event 1: CVS Announces Merger with Caremark

Company	Tuesday Close 10/31/2006	Thursday Close 12/2/2006	Two Day % Change	Direction
Large Independent PBMs				
MHS	53.50	51.40	-3.9%	**Down**
ESRX	63.72	61.84	-3.0%	**Down**
Large Drugstore Chains				
WAG	43.68	42.21	-3.4%	**Down**
RAD	4.68	4.68	0.0%	
CVS	**31.38**	**28.86**	**-8.0%**	**Down**
Market				
S&P	1,372.19	1,367.34	-0.4%	

Event 2: Express Scripts Announces Unsolicited Bid for Caremark

	Friday Close 12/15/2006	Tuesday Close 12/19/2006	Two Day % Change	Direction
Large Independent PBMs				
MHS	52.06	52.38	0.6%	**Up**
ESRX	**68.66**	**72.26**	**5.2%**	**Up**
Large Drugstore Chains				
WAG	44.50	45.66	2.6%	**Up**
RAD	5.32	5.12	-3.8%	**Down**
CVS	30.52	29.98	-1.8%	**Down**
Market				
S&P	1,427.09	1,425.55	-0.1%	

Source: Yahoo Finance Graphs

The Motive for the CVS-Caremark Merger

It has been reported that the CEO's of both companies began talking a year ago about a potential merger. We believe that what finally drove the parties to consummate the deal was an announcement by Wal-Mart that its retail pharmacies would be offering a number of generic drugs for $4 per prescription.

Most Wall Street analysts downplayed the impact of this announcement. They viewed it though traditional price theory and concluded that the $4 price would cause only a limited number of people to "schlep" the extra miles in order to save a few dollars.

We view the Wal-Mart announcement as more than an innocuous "publicity stunt". The specificity of the $4 price was designed to be the tipping point of an "idea epidemic" that large, independent PBMs might not be negotiating the best possible deals for clients. Wal-Mart's strategy is to induce plan sponsors to put more pressure on their PBM vendors to bargain harder with the large drugstore chains. This pressure would destabilize tacit collusion among the Big 3 pharmacy benefit managers (PBMs) – Caremark Rx, Medco Health Solutions, and Express Scripts -- to hold up retail prices in order to make their mail order operations price competitive without margin erosion.

Without the merger, no independent PBM with captive mail order operations has an incentive to steer demand to any retailer. But, with the merger, Caremark would have the incentive to create greater retail volume to offset lower unit margins on retail prescriptions. Caremark would create this greater price elasticity of demand for CVS by moving toward a preferred provider retail network with real incentives for both plans and their members to choose CVS.

One purpose of this paper is to examine in more detail the precarious state of the CVS business model. A disaggregation of CVS's income statement for the last six years will be presented to

support our contention that there is a significant disparity in operating income of CVS's pharmacy business versus the rest of its business known in the industry as the front store. This paper complements our earlier work on making the Walgreen business model more transparent. [1]

We believe that the CVS-Caremark merger marks the beginning of a drugstore preferred provider war. We will present a number of insights into sensible partners for plans and PBMs by comparing state maps of drugstore concentration with maps of the dominant healthcare plan by state.

Based on our prior work on Walgreen's business model, we instantly sensed that the CVS-Caremark merger had something to do with the vulnerable state of CVS's business model Even though it was announced as a "merger of equals", we were sure that CVS was the suitor and that Caremark was the catch. But, why did Caremark not command a premium over its existing stock market price?

Caremark's motive for agreeing to this merger is a mystery to us, and to Wall Street. Did it have something to do with trends in the PBM industry? Did it have something to do with Caremark's competitive situation within the industry? Or, was it motivated by some particular stock option situation involving Caremark's CEO, Mac Crawford?

There is one piece of evidence suggesting that the merger is **not** about market share of the Big 3 PBMs. It has been reported by Reuters that the CEO of CVS, Tom Ryan, met with the CEO's of two unnamed PBMs "to discuss industry matters" before the merger was announced.[2] The "unnamed" PBMs were likely Express Scripts and Medco. The significant of this revelation is that CVS found it important to discuss the impending merger with PBMs, and not drugstore chains. It is likely the purpose of these meeting was to assure Express Scripts and Medco that CVS would continue to work cooperatively with them even though CVS would be merging with their arch rival, Caremark.

Rejecting Value-Creation and Purchasing Power as Motives

We contend that the motive for the CVS-Caremark merge is revenue and market share as opposed to cost or value creation. The management of the two companies would deny this. Their public stance is that the merger is motivated by cost and value creation, although they are vague as to what steps they will be taking to achieve these goals. Consider the following Associated Press summary of the CVS-Caremark merger: [3]

> But the combined company to be called CVS/Caremark Corp. will be able to start saving the $400 million annually starting at the end of 2008, Howard A. McLure, Caremark's senior vice president and chief operating officer, said Wednesday. The buyout is still contingent on approval from shareholders and regulators.
>
> These are savings that "I don't think you could obtain through a joint venture," McLure said at Merrill Lynch investor conference in New York. "These are mainly product acquisition costs, which I think you've got to have the transaction in order to get."
>
> Dave Rickard, chief financial officer at CVS, declined to elaborate on specifics about where the companies will find those savings.
>
> "Purchasing is the majority of it, and the purchasing synergies are expected to be nearly immediate," he said. "There is some operational efficiency cost reduction, and there is some overhead cost reduction. There are no revenue synergies within that $400 million number."

While senior officials cite cost-saving as the primary benefit of the merger, the CEO's of the two companies see "enhancing value" as the motive for the merger. Consider the following quote from CVS CEO Tom Ryan: [4]

> "Over the past year, Mac (Caremark CEO) and I have developed a shared view of where the healthcare market need to go and how we can work together to get there first. Employers and health plans want to control costs, but also want their plan members to have access to a full range of integrated pharmacy services… . Together, CVS and Caremark will help manage the costs and complexities of the U.S. healthcare system, offering unparalleled access and driving superior healthcare outcomes, enhancing value for employers, health plans, and consumers."

The problem with believing this as the motive for the merger is that the Big 3 PBMs no history of monetizing services. Clients of the Big 3 PBMs do not pay any significant management fees, such

as per-member-per-month charges. The Big 3 PBM business model has been all about using hard-to-monitor margins on prescription transactions, rebate retention, and so-called “data fees” from brand drug manufacturers to subsidize value-added services such as formulary development and compliance, drug utilization review, and disease management. It is likely that clients would balk as significant fees to pay for new services created by the merger such as consumer-directed healthcare.

The problem with believing that purchasing power is the motive for the CVS-Caremark merger is that CVS can exercise discretion only in choices of generic drug manufacturers. For drugstore chains, the demand for brand drugs is a derived demand where PBMs (and physicians) are the only entities in the drug supply chain that can exercise discretion in the choices of brand drugs that are deemed therapeutic equivalents.

The table below presents an estimate of purchasing power of Walgreen, CVS, and the Big 3 PBMs. For generic drugs, purchasing power is measured by the number of prescriptions filled at retail or by mail order operations. We do not have estimates of the number of prescriptions filled by the mail order pharmacies that are part of the PBM operations of the drug chains, but that is less than 10% of the total filled by their retail outlets.

For brand drugs, purchasing power is measured by the number of prescriptions managed by PBMs. Again, we do not have estimates of the number of prescriptions managed by the PBM operations of drug chains, but that is not material here.

The table indicates that the CVS-Caremark merger adds nothing to Caremark’s brand purchasing power, but does add to generic drug purchasing power. The problem here is the generic drug industry is so competitive now that their margins are already slim. There is not much more generic drug manufacturers can concede to a new, larger entity in the supply chain.

On the other hand, the Express Scripts-Caremark merger would create the most powerful "countervailing power" to brand drug manufacturers in the United States. However, in other papers, we have contended that the notion of the Big 3 PBMs as pro-competitive, countervailing powers is problematic.

Estimate of Purchasing Power of Drugstore Chains and PBMs

Institution	Rank and Type	Source	Retail Rx Fill Millions Rx		Mail Order Rx Fill Millions of Adj Rx		Purchasing Power Generic Retail+Mail Order Rx Millions Rx	Purchasing Power Brand Rx Managed by PBM Millions Rx
Walgreen	# 1 Drugstore Chain	10-K ending 8/31/05	490	+		=	490	
CVS	# 2 Drugstore Chain	10-K Ending 12/31/05	433	+		=	433	
Medco Health Solutions	# 1 PBM	10-K Ending 12/31/05	0	+	262	=	262	540
Caremark Rx	# 2 PBM	10-K Ending 12/31/05	0	+	174	=	174	478
Express Scripts, Inc	# 3 PBM	10-K Ending 12/31/05	0	+	120	=	120	437
Merger Proposals								
CVS-Caremark	# 2 Chain+ # 2 PBM	pro forma	433	+	174	=	**607**	478
Express Scripts-Caremark	# 2 PBM + # 3 PBM	pro forma	0	+	294	=	294	**915**

Adj Rx: mail order Rx multiplied by 3

And Then Again, Maybe Revenue and Market Share is the Motive

On January 4, 2007, Express Scripts appealed directly to Caremark stockholders to vote against the CVS merger proposal. Express Scripts stressed that the merger of two PBMs would produce more cost saving, which it placed at $500 million a year, than the merger of drugstore chain and a PBM, which CVS placed at $400 million a year. Within several hours, CVS CEO Tom Ryan countered with press release that represented the first reference to the possibility that the CVS-Caremark merger might produce some "incremental revenues", something that a merger of two PBMs could not achieve: [5]

> "In contrast, our bid offers not only significant cost synergies, which we have conservatively estimated at $400 million, but also significant opportunities to drive incremental revenues that only a drugstore/PBM combination can achieve…."

PBMs as 'Enablers' of the Drugstore Chain Business Model

The deterioration of CVS's business model during the past six years has been "enabled" (as in assisting someone to persist in self-destructive behavior) by the Big 3 PBMs. Plan sponsors hire PBMs for their expertise in negotiating prescription reimbursements with retail drugstores. At the same time, the Big 3 PBMs have captive mail order pharmacy operations that compete with retailers.

Having the power to price retail pharmacies has created a situation where the Big 3 PBMs tacitly collude to hold up prices at retail in order to offer their client plan sponsors lower mail order prices without suffering margin erosion. One piece of evidence that this hold up is occurring is the lack of preferred provider retail pharmacy networks with significant co-pay and reimbursement differences. Another piece of evidence is that Medco had to resort to predatory pricing of mail order brand prescriptions in order to offer the FEHPB prices so attractive that they would consider steering members to their captive mail order pharmacies.[6] Another is the PBM response to an arbitrary increase in the average wholesale price (AWP) mark-up ratio in 2002.[7]

One final piece of evidence is a survey of prices offered by various Medicare-endorsed, discount prescription card programs in the year preceding Medicare Part D.[8] The survey revealed that the card sponsored by PharmaCare, CVS's own captive PBM, was the price leader. We contend that this result demonstrates the degree to which PBMs can get better pricing from retailers if they are not worried about protecting their captive mail order operations.

Preferred provider networks with real differentiation -- a form of price competition – are common in other areas of managed care like hospitals and physicians groups where conflict of interest is deterred by strict rules prohibiting ties between payers and providers. The payer-as-provider conflict of interest should end when a PBM with captive mail order operation is itself a captive of an insurance company. Here the interest of a captive PBM is aligned with the parent insurance

company. The common objective is to get the best price regardless of channel of distribution. Examples of this corporate structure include Aetna, CIGNA, WellPoint, and Prime Therapeutics, which is owned by Blue Cross Blue Shield (BCBS) licensees.

It is a mystery to us why insurance companies with captive PBMs, like Aetna and Prime Therapeutics, have failed to develop highly differentiated retail pharmacy networks. This might be understandable for Aetna and CIGNA because their membership is spread out nationally and they lack the local critical mass necessary to be a potent negotiator with CVS and Walgreen. But, this is not the case with Prime Therapeutics or WellPoint's PBM because they often represent BCBS plans that are the dominant healthcare plan in the states in which they do business.

It could be that being the dominant plan in a state works in opposite directions as a factor in network development. On the one hand, the dominant plan has great bargaining power with local providers. On the other hand, the dominant plan faces little competition locally so there is little pressure to push the managed care envelope at the expense of member freedom of choice. This might be the reason why captive PBMs of BCBS licensees historically have not shown interest in preferred provider pharmacy networks.

In the CVS-Caremark deal, CVS was the suitor and Caremark was the catch. We expect Walgreen and Rite-Aid also will take the lead creating preferred provider networks. It is the drugstore business with its "bricks and mortar" that is vulnerable to a new era of price competition. The Big 3 PBMs have demonstrated a remarkable ability to offset margin pressure in one area by adjusting margins on other services.[9] With the exception of its mail order operation, PBMs are basically application software providers with no real "bricks and mortar" other than their computer systems. The PBM business model could easily adapt to an era of price competition and reduced mail order margins by increasing prices for other services and by reversing the trend toward lower rebate retention rates.

Making the CVS Business Model Transparent

Large drugstore chains present their profit and loss statement to the public in a similar way. The presentation is clearly designed to steer a narrow course between the need to satisfy accounting regulations for segment reporting and the desire to mask the relative profitability of individual business segments. The chains disclose sales levels and growth rates by segment. But, they provide no breakdown of cost of sales, gross profit margins, operating expenses, and net income by line of business.

Three kinds of qualitative statements about gross profit margins are usually presented in financial statements submitted quarterly to the Securities and Exchange Commission: (1) the gross profit margin on generic prescriptions is greater than the gross profit margin on brand name prescriptions; (2) the gross profit margin of the front store is greater than the gross profit margin of the pharmacy; (3) the gross profit margin on cash sales – now less than 6% for each chain – is greater than the gross profit margin on sales covered by health insurance. The following is a typical statement by CVS on financial performance by segment.[10]

> Gross margin, which includes net sales less the cost of merchandise sold during the reporting period and the related purchasing costs, warehousing costs, delivery costs and actual and estimated inventory losses, as a percentage of net sales was 26.8% in 2005. This compares to 26.3% in 2004 and 25.8% in 2003.
>
> Our pharmacy gross margin rate continued to benefit from an increase in generic drug sales in 2005, which normally yield a higher gross margin than equivalent brand name drug sales.
>
> Our gross margin rate continues to be adversely affected by pharmacy sales growing at a faster pace than front store sales. On average, our gross margin on pharmacy sales is lower than our gross margin on front store sales. Pharmacy sales were 70.2% of total sales in 2005, compared to 70.0% in 2004 and 68.8% in 2003.
>
> Sales to customers covered by third party insurance programs have continued to increase and, thus, have become a larger component of our total pharmacy business. On average, our gross margin on third party pharmacy sales is lower than our gross margin on non-third party pharmacy sales. Third party pharmacy sales were 94.1% of pharmacy sales in 2005 and 2004, compared to 93.2% in 2003.

There are two keys to a full disaggregation of CVS's income statement by segment. One is an estimate of the gross profit margin of the pharmacy segment. Given that figure from outside annual data provided by the National Association of Chain Drug Stores, simple algebra can be used to derive the gross profit of the front store based on CVS's own disclosures of sales percentages by segment and the aggregate gross profit margin. [11] [12]

Large drugstore chains often boast that the front store gross profit margin is higher than that of the pharmacy operation as if this is sufficient assurance that the front store's financials are strong. But, the bottom line is operating income margin, not gross profit margin, and that is the difference between the gross profit margin and operating expense margin. Disaggregation of operating expense by segment is the final step to making CVS's business model fully transparent.

This allocation of operating expenses by segment is subjective because it is hard to figure out the "drivers" of such costs. Chains probably have a cadre of cost accountants working full time on this task because understanding the profitability of individual business units is key to effective management of a large company. Any judgment of our effort in this area must be couched in relative terms.

It is reasonable to separate drugstore operating expenses in three classes -- labor, facilities, and a big "bucket" for all other selling, general, and administrative costs. Labor is a relatively large operating expense for drugstore chains because they classify all labor as an operating expense rather than classify "direct" labor as cost of goods sold as is done by manufacturers.

The table below presents our allocation of CVS's 2005 operating expenses by segment. Even though CVS's pharmacy operation accounts for 70.2% of sales, we estimate that it accounts for only 42% of total operating expenses, including depreciation and amortization.

The pharmacy operation is a relatively efficient user of space as measured by sales per square foot. That "little hole in the wall" in the back occupies only about 20% of floor space -- 2,600 square feet of a typical 13,000 square store. Yet, it accounts for 70% of sales.

The pharmacy is also a relatively efficient user of labor even though individual pharmacists are highly paid. We estimate that the pharmacy accounts for about 55% of aggregate labor-related operating expenses, but, again, the pharmacy generate 70% of sales.

Allocation of CVS's 2005 Operating Expenses						
Sales	**Operation**	**Labor**	**Facilities**	**Other**	**Total**	
70.2%	**Pharmacy**	55.0%	20.0%	40.0%		
29.8%	**Front Store**	45.0%	80.0%	60.0%		
	Total	100.0%	100.0%	100.0%		**Derived OE Allocation**
$ 25,978	**Pharmacy**	$ 2,167	$ 473	$ 630	$ 3,271	**42%**
$ 11,028	**Front Store**	$ 1,773	$ 1,891	$ 946	$ 4,610	**58%**
$ 37,006	**Total**	$ 3,941	$ 2,364	$ 1,576	$ 7,881	**100%**
	% of Total	50.0%	30.0%	20.0%	100.0%	

The key result is that CVS's front store operating income has been negative for the last five years. (See graphs to follow and derived data in Appendix I) Even though CVS's front store enjoys a relative high gross profit margin, this has been eclipsed in recent years by a rising operating expense margin.

For CVS, the profitability of the pharmacy fortunately masks the red ink generated by its front store. We believe that the only difference between large drugstore chains today and dime store dinosaurs like Woolworth and McCrory's is the "little hole in the wall" in the back.

It is ironic that pharmacy profitability is higher today under managed care than previously when fee-for-service was prevalent. The proximate source of this new pharmacy profitability has been the explosive growth of drugs for chronic illnesses that has unleashed tremendous economies of scale and falling operating expense margins.

However, it is the job of PBMs to understand this dynamic. PBMs should have pressed for steeper prescription discounts in the face of a rising trend in drug costs in order to force gross profit margins to mirror the downward trend in operating expense margins. But, the Big 3 PBMs did not. The result has been a growing cross subsidy in the chain drugstore business model.

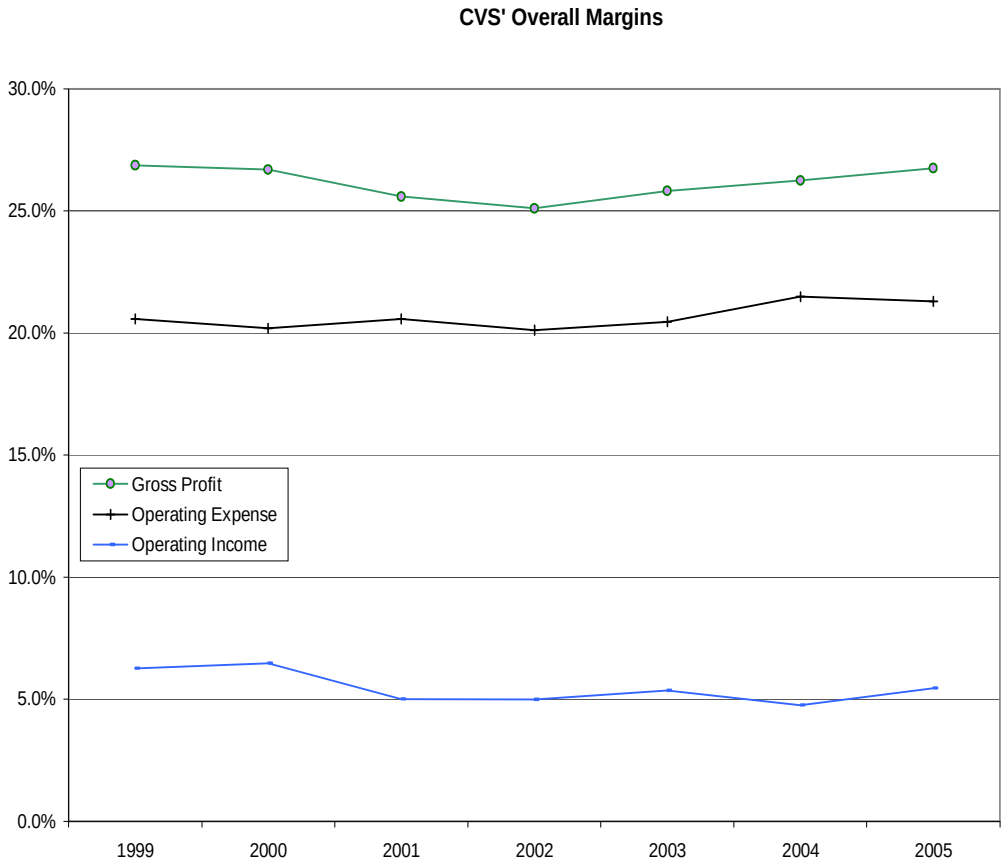
This is how PBMs can be seen as “enablers” of the deterioration of the drugstore chain business model.

If retailers did not have the pharmacy profits to subsidize the front store, they would be forced to make changes designed to increase the net profitability of their front store. This would mean high prices for convenience goods and/or reduced operating expense margins through reduced store expansion in order to prop up front store sales per store.

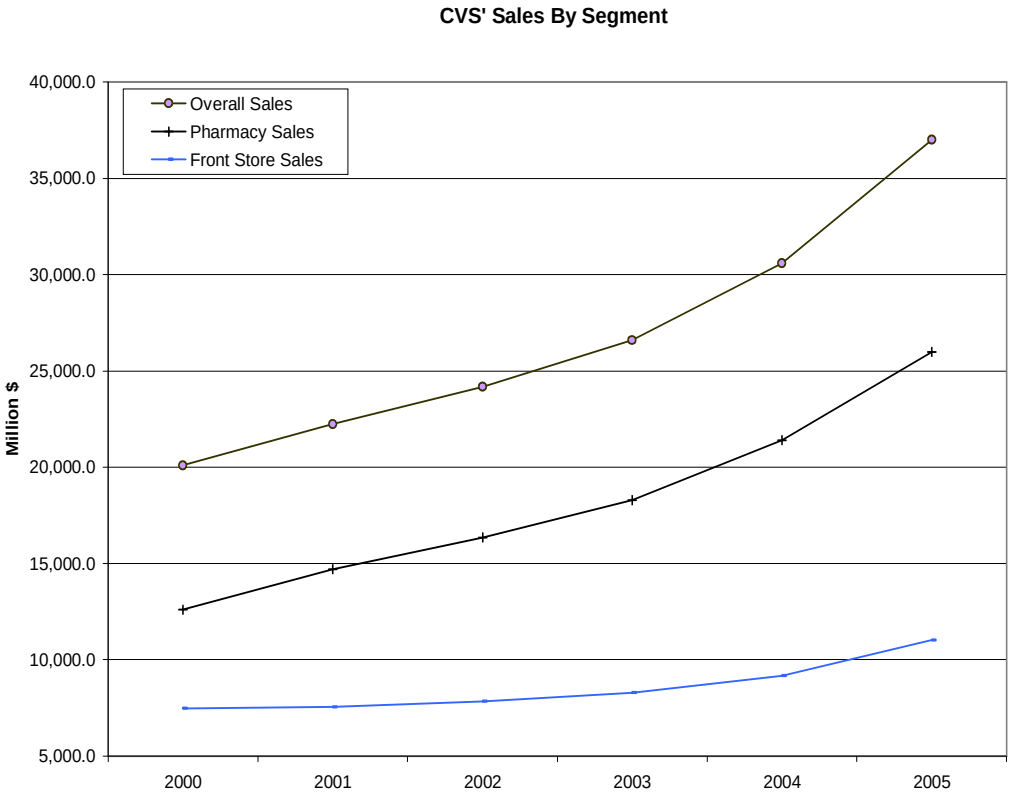
But such moves play right into the hands of Wal-Mart. Wal-Mart can compete on price, but not on convenience. By forcing the big chain drugstores to eliminate cross-subsidies in its business model, Wal-Mart will be raising the cost of convenience. Wal-Mart is really after the front store as much as the pharmacy. The CVS-Caremark merger is designed to shore up pharmacy gross profits – increased traffic to offset lower unit margins -- so as to avoid increasing the cost of front store convenience.

The following graphs summarize our effort at making CVS’s business model transparent. The data that supports these graphs is displayed in Appendix I.

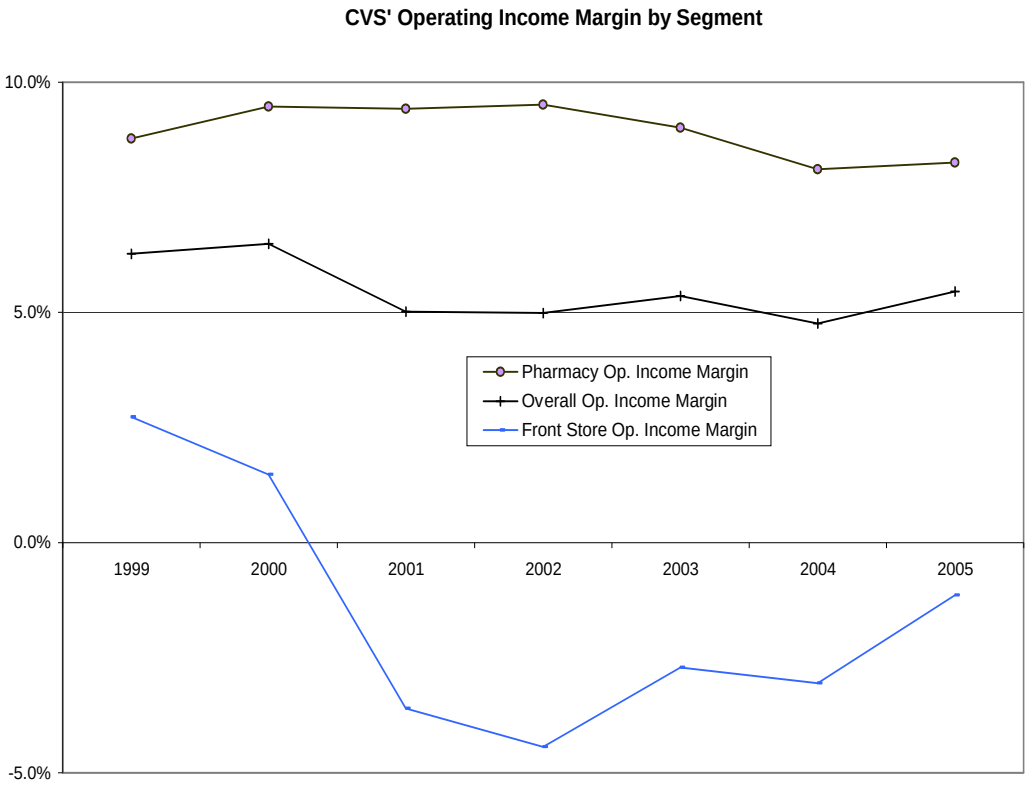
Even though CVS's overall profitability has been positive and steady…



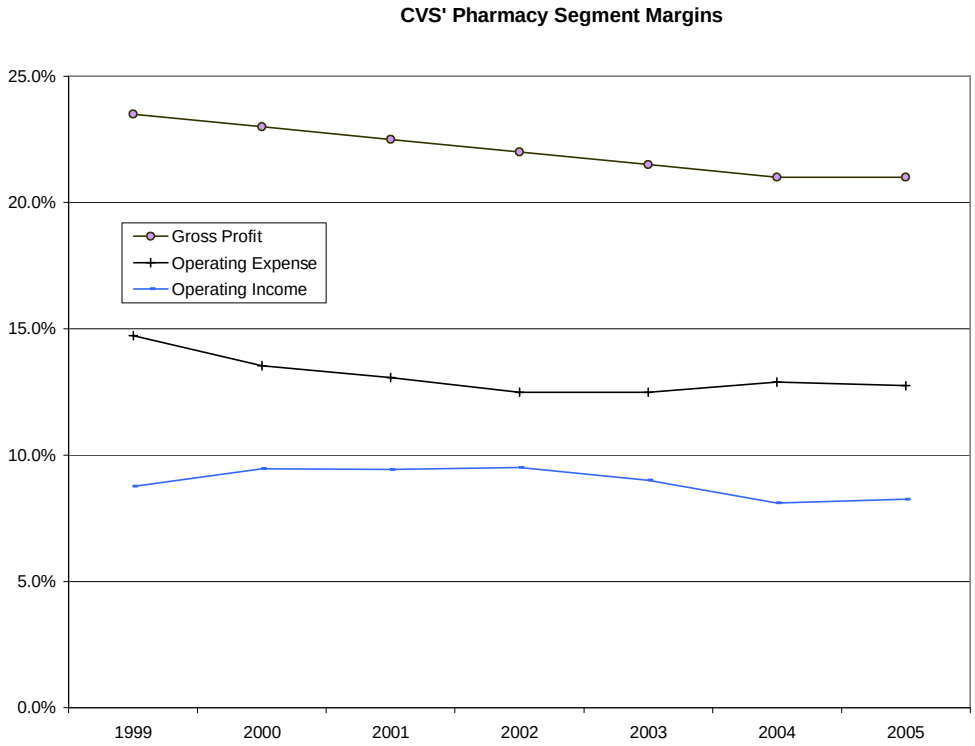
There is a great disparity in the sales growth rates of CVS's two segments…



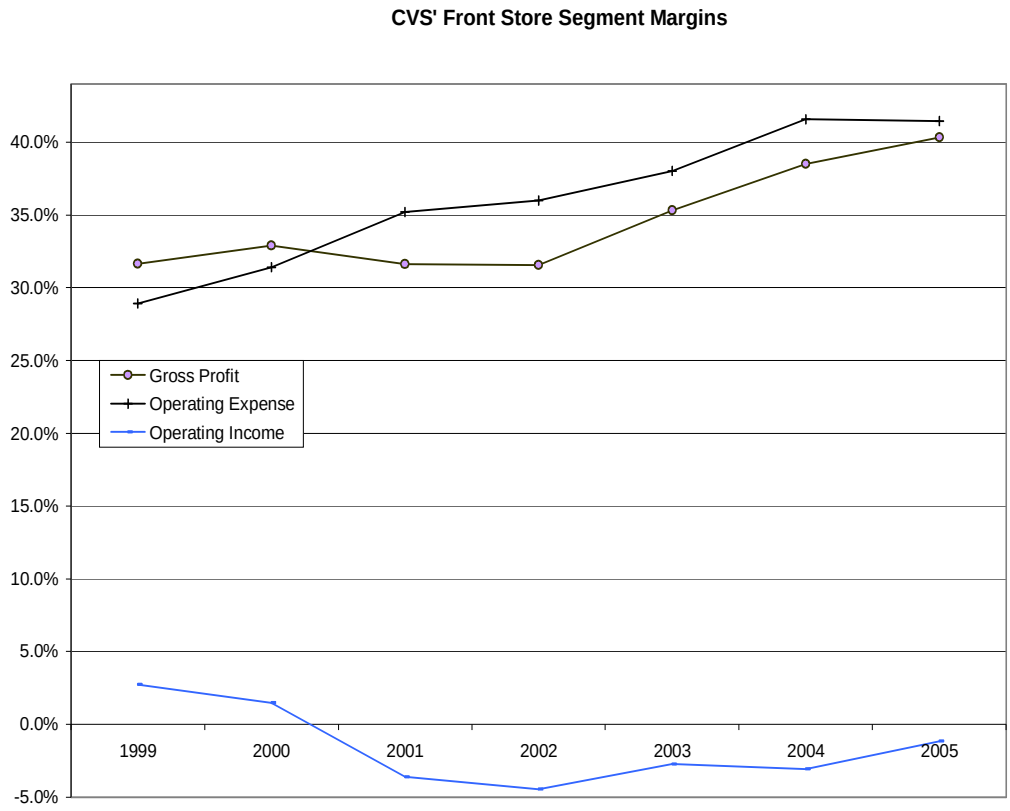
And a great disparity in profitability by segment.



CVS's pharmacy operation has enjoyed a healthy operating income margin despite a declining gross profit margin because expense margins have also declined due to economies of scale.



On the other hand, the CVS's front store operations have become unprofitable as rising gross profit margins have been eclipsed by rising operating expense margins.



The Coming Preferred Provider War

Walgreen has signaled that it does not buy the line that the reason for the CVS-Caremark merger is to increase purchasing power. It senses a move against its market share. Consider the following quote by Walgreen's director of finance, [13]

> Walgreen Co. said it is remaining "cautious" about CVS Corp.'s $21 billion purchase of Caremark Rx Inc.
>
> "We think there will be attempts by this entity to try to steal our customers," Rick Hans, Walgreens' director of finance, said at a conference Tuesday.
>
> "We certainly have a certain amount of trepidation about the merger," Hans said. "Competitively, we will do whatever we need to do to respond."

Currently, PBMs create extensive retail networks with upwards of 60,000 pharmacies. Usually, the co-pay is the same for all pharmacies within the network. Also, PBMs generally are content to set a single reimbursement rate for all retailers – large or small. This benevolence allows low cost retailers like CVS and Walgreen to retain the "producer surplus". All of this will likely change with the CVS-Caremark merger.

Caremark will try to convince its clients to adopt a preferred provider network that favors CVS. As an incentive to use the preferred provider, it is reasonable to expect Caremark to institute the following:

(1) Low to nil co-pays if CVS is chosen, higher co-pays if another retailer is used

(2) 90-day retail prescriptions at CVS only, if requested by the client

(3) OTC drugs, maybe even vitamins, covered by plan if bought at CVS only

Of course, to insure enthusiasm for this differential treatment, Caremark will offer plans lower reimbursement rates if their members choose CVS over some other retailer.

Mapping the Preferred Provider War

We see this as series of fights to win the preference of the dominant plan in each state – generally Blue Cross Blue Shield (BCBS) plans. Increased market share will go to the winner. The purpose of this section is to determine which states will be hotly contested and the strategy each of the three major drugstore chains might adopt. Another section will lay out the effect of these battles on supermarket and community pharmacies.

Geographic concentration of plan members and retail stores will be an important factor in negotiating price concessions in return for preferred provider status. Because the chains will be the initiators of this war, the starting place for understanding strategy is a map of relative store concentrations, adjusted by average sales per store, of the three chains. Below is a map of states where a single chain is considered dominant if it has at least 50% of combined sales-adjusted store count and leads each of the other two by 10 percentage points. The state is colored "blue" if Walgreen is considered dominant, "red" if CVS is considered dominant, and "green" if Rite-Aid is considered dominant. If no chain has at least a 50% share with a 10 percentage point lead, then the state is considered a "swing" state and colored "black".

Appendix II presents a list of store count by state, average sales per store, and relative market share, as measured by store count weight by average sales per store, of the three chains. The data is for the 2005 fiscal year and are taken from annual 10-K's submitted to the SEC.[14] The 2005 count for CVS in California was increased by 350 to recognize its recent acquisition of stores of Sav-On in Southern California.

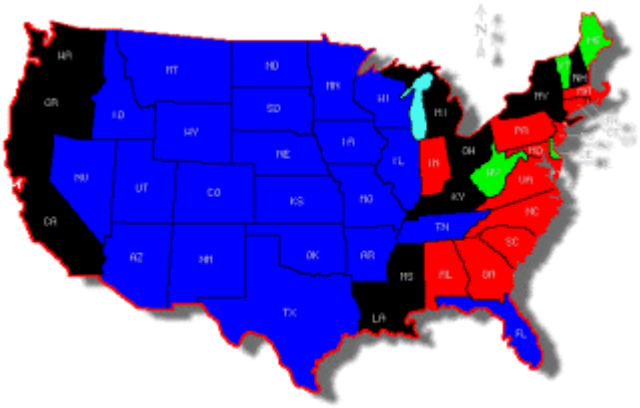
The data for Rite-Aid does **not** include 1,858 stores in the Brooks and Eckerd chain acquired from Jean Coutu of Canada in August, 2006. [15] These stores will add to Rite-Aid's concentration in the Mid-Atlantic region and create a new presence for Rite-Aid in four states – Massachusetts, Rhode Island, North Carolina, and South Carolina. At most, this addition may move a couple Mid-

Atlantic States from the CVS column to the swing column. The additions are not expected to move any swing state into the Rite-Aid column.

Generally, the battles outside the swing states will be between Walgreen and Rite-Aid in the West and between CVS and Rite-Aid in the MidAtlantic and East. The outcome of this war is likely to make the dominant chain in any one state even more dominant. This means that Rite-Aid is likely to be a big loser of market share.

Drugstore Concentration by State –

Walgreen (Blue) CVS (Red) Rite-Aid (Green) Swing (Black)



The Key Swing States

The real contests will take place in ten "swing" states where no chain has more than 50% share and where the leading chain's advantage is less than 10 percentage points. The table below presents sales-adjusted store count share in each of the twelve swing states of the three chains. It also presents the top two healthcare plans in each state as measured by their share of the combined PPO/HMO market. Throughout the rest of this paper, we use data compiled by the American Medical Association on healthcare plan market share by state in deriving our map of the dominant plan by state. This data can be found in the appendix to an AMA report entitled **Competition in Health Insurance: A Comprehensive Study of US Markets.** [16]

The Key States in the Coming Preferred Provider War				Average Sales Per Store - Mil $ 5.43	4.40	3.28
	Store Count			Sales-Adjusted Store Count Share		
Swing States	WAG (Blue)	CVS (Red)	RAD (Green)	WAG (Blue)	CVS (Red)	RAD (Green)
California	408	371	588	38.3%	28.3%	33.4%
Kentucky	59	56	116	33.8%	26.0%	40.2%
Louisiana	102	84	68	48.3%	32.3%	19.5%
Michigan	165	228	317	30.5%	34.1%	35.4%
Mississippi	37	29	28	47.8%	30.4%	21.9%
New Hampshire	11	27	38	19.7%	39.2%	41.1%
New York	69	421	383	10.7%	53.2%	36.1%
Ohio	173	308	236	30.6%	44.2%	25.2%
Oregon	37		71	46.3%	0.0%	53.7%
Washington	90		131	53.2%	0.0%	46.8%
Total*	1151	1524	1976			
USA Total	**4,953**	**5,770**	**3,223**			
Swing as a % of Total	**23.2%**	**26.4%**	**61.3%**			

Key Strategic Partners in Swing States

Swing States	Insurance Plan	PBM	Plan Share of State	Insurance Plan	PBM	Plan Share of State
California	Kaiser	Kaiser	33.0%	WellPoint	WellPoint	22%
Kentucky	WellPoint	WellPoint	49.0%	Humana	Express Scripts	14%
Louisiana	BCBS-LA	Prime Therapeutics	56.0%	UnitedHlealthCare	Medco	27%
Michigan	BCBS-MI	Medco	63.0%	Ford Health Sys	Medco	9%
Mississippi	n.a.	n.a.		n.a.	n.a.	
New Hampshire	WellPoint	WellPoint	57.0%	CIGNA	CIGNA	21%
New York	GHI	Express Scripts	25.0%	Empire BCBS	WellPoint	18%
Ohio	WellPoint	WellPoint	40.0%	Medical Mutual	Medco	17%
Oregon	Regence BCBS	Regence Rx	30.0%	Providence Health	Providence Health	27%
Washington	Premera BC	Medco	32.0%	Regence BS	Regence Rx	26%

Sources: 10-K's for Store Concentration; AMA Study of Competition for Plan Concentrations

These ten states represent 23.2% and 26.4% of Walgreen's and CVS's sales-adjusted store count, respectively. But, they represent 61.3% of Rite-Aid's sales adjusted store count. Both Walgreen and CVS can afford to lose the battles in each of these swing states and still survive.

But, Rite-Aid will be battling for its life in the swing states. Major loses by Rite-Aid in the four most populous swing state – California, Michigan, New York and Ohio – would be devastating. The likely loser in the battle between #1 Walgreen and #2 CVS will be #3 Rite-Aid. This result is not surprising as it is generally the case that the strongest, most efficient firms gain market share in a price war.

Several other insights emerge from the above tables:

(1) The merger does help not help CVS in swing states as Caremark is not a vendor of any of the top plans in these states. In a later section, we will show Caremark's customers are concentrated in the Beltway States and Mid-Atlantic States where CVS dominants. The pairing of CVS and Caremark makes sense, but the merger seems defensive rather than designed to expand CVS's share in swing states.

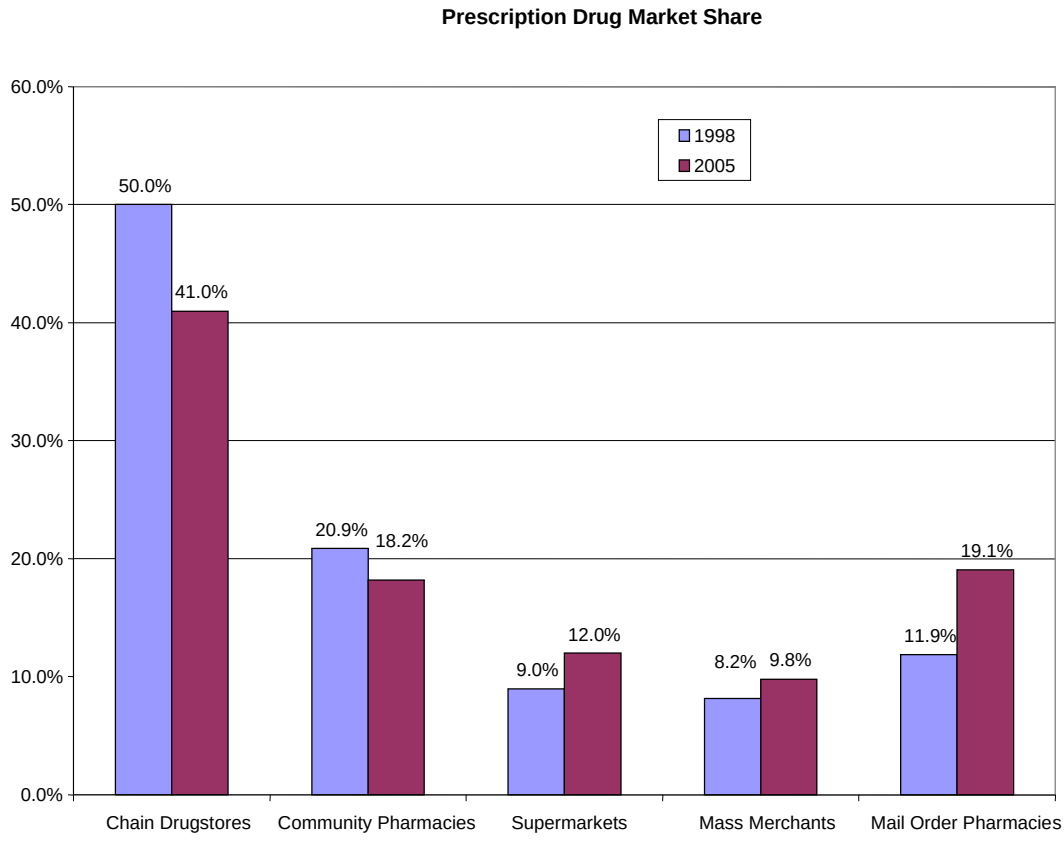
(2) Walgreen does not need any of the Big 3 PBMs to win the coming preferred provider war. Walgreen can gain market share in the swing states by signing up Prime Therapeutics, Regence Rx, and Kaiser. As we show later, Prime Therapeutics and Walgreen are natural allies as all of the BCBS plans served by Prime are in "blue" states. For Walgreen, splitting WellPoint with CVS would be "icing on the cake".

(3) WellPoint is the single most important strategic partner of the war, but their territory covers both "red", "blue" and swing states. For CVS, splitting WellPoint's allegiance with Walgreen is key to avoiding a net loss in market share. It would be devastating to CVS if Walgreen managed somehow to win WellPoint's total allegiance.

(4) Rite-Aid's best hope to avoid a devastating loss in swing states is to partner with Medco. But Rite-Aid needs Medco more than Medco needs Rite-Aid as most of plans that Medco serves have no particular geographic concentration.

The Impact on Other Pharmacy Groups

During the past eight years, both drugstore chains and community pharmacies have lost market share to supermarkets, mass merchants, and, especially, mail order pharmacies. [17] [18] The top supermarkets chains with pharmacies are Kroger, SuperValu (recently buying the Albertson's chain), and Safeway. The top mass merchants with pharmacies are Wal-Mart and Target.



First and foremost, we believe that the CVS-Caremark merger and the coming preferred provider war is about chain drugstore market share with Rite-Aid being the big loser. Secondary, it is about stopping the trend in share gain by supermarkets. Supermarket pharmacies compete effectively with drugstore chains from a convenience standpoint. Unlike drugstore chains, supermarket pharmacies are not burdened by the need to subsidize other segments of the business. Supermarket pharmacies could weather more price competition and margin erosion

without destabilizing the whole grocery store business model. The benefit of a price war among the three drugstore chains is that their arch rival supermarket chains will take a significant hit.

Today, less than 6% of chain drugstore customers are “cash-only.” Even if mass merchants like Wal-Mart and Target take all of this business away from drugstore chains with their $4 / generic prescriptions programs, it would represent only a swing of 2.4 percentage points. Walgreen and CVS should be able to cover this loss and more by taking share from Rite-Aid and supermarkets.

We do not believe that CVS wants to gain share at the expense of Caremark. While CVS might wish for Caremark to allow 90-day prescriptions to be filled at retail, it is certainly the last item on its list of ways to increase retail market share. However, the coming preferred provider war generally will lower reimbursement rate differentials between retail preferred providers and mail order pharmacies. Plan sponsors generally will be less receptive to suggestions to the steer members to mail order. So while the CVS might not intend on cannibalizing sales from Caremark, the overall trend to mail order should slow, or reverse, and all retail chains will benefit by this new era of retail price competition at the expense of mail order pharmacies.

We believe that community pharmacies will largely be unaffected by the coming preferred provider war. In the past, both large chains and community pharmacies received the same reimbursement and the same status. But, the uniform price approach to network reimbursement gave the large chains a healthy “producer surplus” while community pharmacies received a price that just covered their costs.

The Big 3 PBMs will continue to create rather comprehensive networks covering over 90% of all pharmacies in the country. Even though networks in the future are likely to be highly differentiated, PBMs still need to offer high reimbursement levels in order to attract enough community pharmacies to meet the coverage demanded by customers. As longer as customers

demand expansiveness, the reimbursement levels that community pharmacies receive, although just covering their costs, should remain the same despite the coming preferred provider war.

Conflicts within CVS-Caremark

Some members of the retail community have wistfully speculated that CVS will soften up traditional PBM resistance to 90-day retail prescriptions. But, we believe that this is naïve because retail pharmacies now more than ever need increased traffic. The CVS people will be reluctant to press this issue out of fear that it will cause a net loss in retail traffic. If there is to be any change in this area, it will have to come from individual consumers complaining to their plan sponsors.

The real friction will come if the CVS people receive offers from Medco or Express Scripts to be their preferred provider. The Caremark people will press the CVS people not accept such offers because refusal would send a message to plans that Caremark is on only PBM that can deliver a quality preferred provider network in the East and South.

The CVS people might not want to spurn overtures by Medco and Express Scripts because this might drive the two PBMs to seek out Rite-Aid. The bargaining power of Medco and Express Scripts in the East and South is only as effective as the viability of Rite-Aid as an alternative. On the other hand, Medco is more than a bargaining chip for Rite-Aid. The key to Rite-Aid's survival might be partnering with Medco in key swing states like Michigan, New York, and Ohio where Medco serves plans with a large share of the market.

Plan Sponsor Bargaining Power

Plans with geographic concentrations of membership will have the most bargaining power when seeking price concessions from potential drugstore preferred providers. Plans dominant in the swing states are typical of the type of plans that dominate all states. Generally, it is a BCBS licensee that is the dominant plan in any one state.

Private insurance companies like Aetna, CIGNA, and United Healthcare will not have as much bargaining power as the "Blues" because their membership is spread out geographically. Only Kaiser concentrated in California, Colorado, Hawaii, and Oregon, and possible Coventry in the Southeast, have sufficient size and geographic concentration to gain some bargaining power.

Generally, self-insured plans and Taft-Hartley plans of large unions won't have much bargain power because of the geographic dispersion of their members. But, there are a few exceptions. Medco services plans sponsored by the automakers and auto unions that are concentrated in Michigan. The Federal Employee Health Benefit Plan (FEHBP) covering approximately 3.5 Million Federal workers, including Congressmen, has a high market share in the Beltway states of Virginia, Maryland, and the District of Columbia.

CVS's Strategy

After comparing maps of drugstore concentration with maps of membership concentration, it becomes apparent that the pairing of Caremark with CVS makes sense from a preferred provider standpoint. According to Caremark's latest 10-K, the FEHBP is its single largest customer accounting for 16% of its business.[19] We believe that the "shared interests" mentioned by CVS CEO Tom Ryan as one of the subjects of his first meeting with Caremark a year ago referred to the FEHBP, whose members primarily reside in the Beltway states dominated by CVS.

Concentration of FEHBP Members in Beltway								
List of Store Count by State - 2005					Sales-Adjusted Store Count Share			
STATE	WAG (Blue)	CVS (Red)	RAD (Green)		WAG (Blue)	CVS (Red)	RAD (Green)	Map Color
District of Columbia	0	48	8		0.0%	88.9%	11.1%	Red
Maryland	18	166	133		7.7%	57.8%	34.5%	Red
Virginia	54	231	133		16.8%	58.2%	25.0%	Red
Total*	72	445	274					
Sources: 10-K's for Store Concentration and Ave Sales Per Store								

There are other states where Caremark and CVS have shared interests. Caremark serves BCBS licensee Horizon in New Jersey and Pennsylvania, both important "red" states for CVS. PharmaCare, the CVS captive PBM, serves the dominant BCBS plan of Rhode Island, an obvious "red" state as it is the location of CVS's corporate headquarters.

As we observed earlier, Caremark does not serve any of the top two plans in the twelve swing states so the merger does not appear to help CVS is those critical areas. The merger looks like a defense of CVS territory in the East, rather than an offensive drive into important swing states for CVS like Michigan, Ohio, and New York.

Walgreen's Strategy

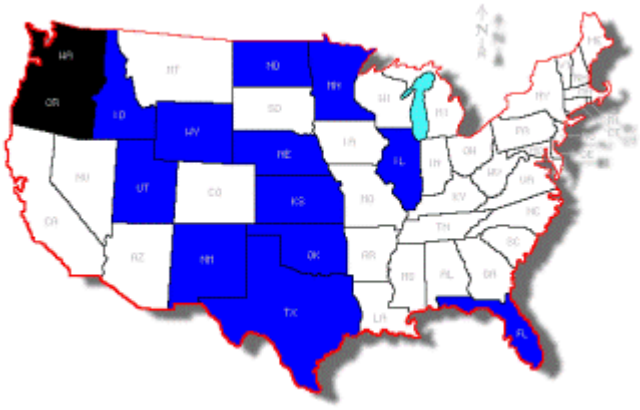
Some Wall Street analysts have speculated that Walgreen might seek out Medco or Express Scripts as a merger partner to be in a position to match whatever moves the combined CVS-Caremark makes. Our overlapping map analysis suggests otherwise.

One of the most important insights derived by this analysis is that **Walgreen does not need any of the Big 3 PBMs to win the coming preferred provider war.**

The first alliance Walgreen's should forge is with Prime Therapeutics – a PBM jointly owned by ten BCBS licensees. These two have a near perfect overlap in geographic concentration. Furthermore, Walgreen is Prime's specialty pharmacy vendor and so they already have a close working relationship.

The other natural alliance would be with Regence who is a BCBS licensee in Oregon and Utah and BS licensee in Washington and Idaho. Regence is served by its own, newly formed captive PBM. While Rite-Aid's biggest threat is CVS in the East, Walgreen could contribute secondarily to Rite-Aid's problems by signing Regence in the Western swing states of Washington and Oregon.

Prime Therapeutics – Regence Rx Territory



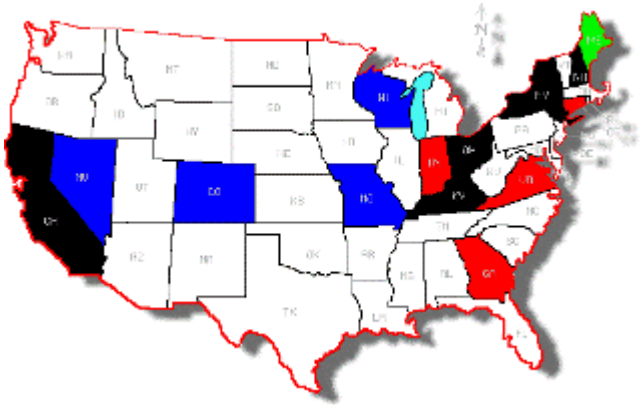
Walgreen's Natural Partners Are Prime Therapeutics and Regence Rx

State	Dominant Chain	Dominant Plan	Plan Share	PBM
Florida	Walgreen	BCBS	34%	Prime Therapeutics
Illinois	Walgreen	BCBS	51%	Prime Therapeutics
Kansas	Walgreen	BCBS	37%	Prime Therapeutics
Minnesota	Walgreen	BCBS	63%	Prime Therapeutics
Nebraska	Walgreen	BCBS	47%	Prime Therapeutics
New Mexico	Walgreen	BCBS	41%	Prime Therapeutics
North Dakota	Walgreen	BCBS	89%	Prime Therapeutics
Oklahoma	Walgreen	BCBS	39%	Prime Therapeutics
Texas	Walgreen	BCBS	35%	Prime Therapeutics
Wyoming	Walgreen	BCBS	72%	Prime Therapeutics
Idaho	Walgreen	BS	35%	Regence Rx
Oregon	Swing	BCBS	30%	Regence Rx
Utah	Walgreen	BCBS		Regence Rx
Washington	Swing	BS	26%	Regence Rx

Sources: 10-K's for Store Concentration; AMA Study of Competition for Plan Concentrations

WellPoint is the largest health insurance company in the United States. It is a BCBS licensee with a dominant position in fourteen states. WellPoint is the single most important strategic partner of the war, but its territory covers both “red”, “blue” and swing states. For CVS, splitting WellPoint’s allegiance with Walgreen is the single most important thing it could do to avoid a net loss in market share. For Walgreen, splitting WellPoint with CVS would be “icing on the cake”.

WellPoint-Anthem-Empire Territory



Wellpoint-Anthem-Empire Territory

State	Dominant Chain	Dominant Plan	Plan Share	PBM
California	Swing	Wellpoint BC	22%	Wellpoint
Colorado	Walgreen	Wellpoint BCBS	36%	Wellpoint
Connecticut	CVS	Wellpoint BCBS	59%	Wellpoint
Georgia	CVS	Wellpoint BCBS	66%	Wellpoint
Indiana	CVS	Wellpoint BCBS	38%	Wellpoint
Kentucky	Swing	Wellpoint BCBS	49%	Wellpoint
Maine	Rite-Aid	Wellpoint BCBS	68%	Wellpoint
Missouri	Walgreen	Wellpoint BCBS	46%	Wellpoint
Nevada	Walgreen	Wellpoint BCBS	35%	Wellpoint
New Hampshire	Swing	Wellpoint BCBS	57%	Wellpoint
New York	Swing	Empire BCBS	18%	Wellpoint
Ohio	Swing	Wellpoint BCBS	40%	Wellpoint
Virginia	CVS	Wellpoint BCBS	64%	Wellpoint
Wisconsin	Walgreen	Wellpoint BCBS	27%	Wellpoint

Sources: 10-K's for Store Concentration; AMA Study of Competition for Plan Concentrations

Medco's Strategy

Most of Medco clients have membership scattered nationwide. Its largest client, United Healthcare, accounts for 23% of Medco's business and has a geographically dispersed membership.[20]. According to one report, unions make up over 25% of Medco's business.[21] Taft-Hartley plans of large national unions also tend to have membership scattered nationwide.

Those plans with geographic concentration that are served by Medco do not fall neatly into any camp. Medco will be a factor in the swing state of Michigan as it serves the health plans of the automakers and the auto unions. Medco also serves the dominant BCBS plan in West Virginia, one of only four "green" states for Rite-Aid. Medco may also want to partner with CVS in the Southeast in order to better serve Coventry. On the other hand, CVS might spurn this limited partnership, hoping that Coventry might drop Medco in favor of Caremark.

Concentration of Members Served by Medco

State	Dominant Chain	Dominant Plan	Plan Share	PBM
Michigan	Swing	BCBS	63.0%	Medco
North Carolina	CVS	BCBS	61.0%	Medco
Pennsylvania	CVS	Highmark	n.a.	Medco
Washington	Swing	Premera BC	32.0%	Medco
West Virginia	Rite-Aid	Mountain States (Highmark)	37.0%	Medco

Sources: 10-K's for Store Concentration and Ave Sales Per Store

Express Scripts' Strategy

The key plans serviced by Express Scripts have state concentrations in the East where CVS dominates. CVS might spurn any attempt at partnering with Express Scripts in the East, hoping that Express Scripts' clients might drop them in favor of Caremark. Express Scripts is more vulnerable than Medco to rebuffs by CVS. The fear of losing clients in the East might be one of the reasons why Express Scripts wants to block the CVS-Caremark merger.

Concentration of Members Served by Express Scripts

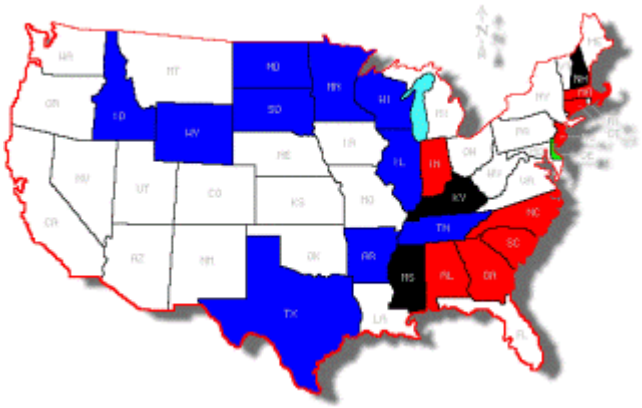
State	Dominant Chain	Dominant Plan	Plan Share	PBM
Delaware	CVS	Carefirst (BCBS)	65%	Express Scripts
D.C.	CVS	Carefirst (BCBS)	n.a.	Express Scripts
Maryland	CVS	Carefirst (BCBS)	37%	Express Scripts
Virginia	CVS	Carefirst (BCBS)	n.a.	Express Scripts
Massachusetts	CVS	BCBS-MA	51%	Express Scripts
New York	Swing	GHI (NY Govt Employees)	25%	Express Scripts
Louisiana	Swing	BCBS-LA	56%	Express Scripts

Sources: 10-K's for Store Concentration; AMA Study of Competition for Plan Concentrations

"Any Willing Provider Laws" As a Strategic Consideration

There are twenty-two state with "any willing provider" (AWP) laws designed to insure that no pharmacy can be denied admittance to a preferred provider network if it is willing to meet the specifications of a provider contract. [22] These laws were a reaction to the emergence of managed care in the 1990's and the use of preferred provider networks as a key technique for holding down healthcare costs. [23] Community pharmacy trade associations have been the prime sponsors of such laws and have been particularly effective at lobbying legislators from rural districts in the South and Plains States to protect community pharmacies from being excluded from pharmacy networks. A "colored" map of AWP states follows:

States with Any Willing Provider Laws



The coming preferred provider war should feature network development with significant co-pay and reimbursement differentials. It is reasonable to assume that PBMs and drugstore chains might be deterred from creating differentiated networks in AWP states. AWP laws as a deterrent might be moot in "blue" and "red" states because of the lack of motivation to go to war in those states.

CVS does have a history of fighting AWP laws.[24] CVS was sued by Walgreen and Stop & Shop when their captive PBM, PharmaCare, named CVS as the exclusive preferred provider of Rhode Islands' BCBS plan. CVS was successful in having the suit dismissed in 2003, but the Rhode Island pharmacy association retaliated by getting the state legislature to consider an AWP law. That effort also failed.

The Rhode Island experience may have been a factor in the decision by CVS to seek a merger, rather than a strategic partnership, with Caremark. AWP laws are keyed to explicit contracts. AWP laws state that if a provider is willing to meet the price concession and related terms of an existing preferred provider contract, that provider cannot be denied a similar offer. Because all transactions between payer (PBM) and provider (drugstore) will be internal for CVS-Caremark

companies, no specific contracts need be drawn up between the two. AWP laws only provide access to specific contracts. In AWP states, Caremark could offer toothless “any willing provider” contracts, at the same time favoring CVS via internal documentation and limited internal accounting of transactions between PBM and retail units.

Unlike CVS, Walgreen’s efforts to form highly differentiated and restrictive networks could be deterred in AWP states. So, AWP laws might help CVS-Caremark turn the two Southern swing states of Mississippi and Kentucky into “red” states and turn the “blue” state of Tennessee into a swing state.

Notes:

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(5) CVS, Press Release, January 4, 2007 Available at http://biz.yahoo.com/bw/070104/20070104005797.html?.v=1

(6) LW Abrams, "Exclusionary Practices in the Mail Order Pharmacy Market," September 2005. Available at www.nu-retail.com

(7) LW Abrams, "PBM Response to an Arbitrary Increase in the AWP Mark-Up Ratio," February 2007 Available at http://www.nu-retail.com

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(9) LW Abrams, "Medco's Transition to a Transparent Business Model," September 2005, Available at http://www.nu-retail.com

(10) Securities and Exchange Commission, CVS, Inc. Form 10-K for the Year ending December 31, 2005

(11) National Community Pharmacy Association, NCPA-Pfizer Digest-in-Brief, November 2006, p 7. Available at http://www.ncpanet.org/pdf/digest06_summary.pdf

(12) Securities and Exchange Commission, CVS, Inc. Form 10-K for the Year ending December 31, 2005 and the Year ending December 31, 2002.

(13) Bloomberg News, "Walgreens Watching CVS-Caremark Deal," November 15, 2005 Available at http://www.chicagotribune.com/business/chi-0611150131nov15,0,2355574.story?coll=chi-business-hed

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(15) Rite-Aid, New Announcement, August 2006. Available at http://www.riteaid.com/company/news/news_details.jsf?itemNumber=844

(16) American Medical Association, Competition in Health Insurance: A Comprehensive Study of US Markets, 2005 Update. Available at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf

(17) Data for 1988 comes from Federal Drug Administration, Profile of Prescription Drug Wholesaling Industry. Available at http://www.fda.gov/oc/pdma/report2001/attachmentg/4.html

(18) Data for 2005 comes from "The Chain Drugstore in Alive and Well: NACDS Profile" Drug Topics, November 2006 Available at http://www.drugtopics.com/drugtopics/article/articleDetail.jsp?id=385556

(19) Securities and Exchange Commission, Caremark, Inc. Form 10-K for the Year ending December 31, 2005. .

(20) Securities and Exchange Commission, Medco Health Solutions, Form 10-K for the Year ending December 31, 2005

(21) Bargaining Digest Weekly, May 27, 2006. Available at http://blog.aflcio.org/?tag=Medco

(22) National Conference on State Legislatures, Managed Care State Laws and Regulations, Including Consumer and Provider Protections, Updated September 2006 Available at http://204.131.235.67/programs/health/hmolaws.htm#2005

(23) Robert L. Ohsfeldt, ET. al. "The Spread of State Any Willing Provider Laws" Health Services Research 33:5 (December 1998, Part II) Available at http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1070332&blobtype=pdf

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Appendix I: CVS Business Model Disaggregation

CVS Business Model

Source	Year	Sales M$	CGS M $	SGA M $	Depr & Amort M $	Pharmacy Share of Sales	# of Store
		A	B	C	D	E	F	G	H
10-K 2002	1999	18,098.3	13,236.9	3,448.0	277.9	58.7%	
10-K 2002	2000	20,087.5	14,725.8	3,761.6	296.6	62.7%	4,133
10-K 2002	2001	22,241.4	16,550.4	4,256.3	320.8	66.1%	4,191
10-K 2002	2002	24,181.5	18,112.7	4,552.3	310.3	67.6%	4,087
10-K 2005	2003	26,588.0	19,725.0	5,097.7	341.7	68.8%	4,179
10-K 2005	2004	30,594.3	22,563.1	6,079.7	496.8	70.0%	5,375
10-K 2006	2005	37,006.2	27,105.0	7,292.6	589.1	70.2%	5,471
Source		10-K	10-K	10-K	10-K	10-K	10-K

Source	Year	% GP Margin	Pharmacy Sales	Fr Store Sales	Overall GP $	Overall GP %	Overall OE %
		A	B	I	J	K	L	M	N
10-K 2002	1999	23.5%	10,623.7	7,474.6	4,861.4	26.9%	20.6%
10-K 2002	2000	23.0%	12,594.9	7,492.6	5,361.7	26.7%	20.2%
10-K 2002	2001	22.5%	14,701.6	7,539.8	5,691.0	25.6%	20.6%
10-K 2002	2002	22.0%	16,346.7	7,834.8	6,068.8	25.1%	20.1%
10-K 2005	2003	21.5%	18,292.5	8,295.5	6,863.0	25.8%	20.5%
10-K 2005	2004	21.0%	21,416.0	9,178.3	8,031.2	26.3%	21.5%
10-K 2005	2005	21.0%	25,978.4	11,027.8	9,901.2	26.8%	21.3%
		NACDS	=C*G	=C-J	=C-D	=L/C	=(E+F)/C

Source	Year	Overall OI M.$	Overall OI %	Pharmacy OE %	Pharmacy OI %	Front Store GP %	Front Store OE %	Front Store OI %
		A	B	O	P	Q	R	S	T	U
10-K 2002	1999	1,135.5	6.3%	14.7%	8.8%	31.6%	28.9%	2.7%
10-K 2002	2000	1,303.5	6.5%	13.5%	9.5%	32.9%	31.4%	1.5%
10-K 2002	2001	1,113.9	5.0%	13.1%	9.4%	31.6%	35.2%	-3.6%
10-K 2002	2002	1,206.2	5.0%	12.5%	9.5%	31.6%	36.0%	-4.4%
10-K 2005	2003	1,423.6	5.4%	12.5%	9.0%	35.3%	38.0%	-2.7%
10-K 2005	2004	1,454.7	4.8%	12.9%	8.1%	38.5%	41.6%	-3.1%
10-K 2005	2005	2,019.5	5.5%	12.7%	8.3%	40.3%	41.5%	-1.1%
		=L-E-F	=O/C	=(.42*(E+F))/J	=I-Q	=(L-(I*J))/K	=(.58*(E+F))/K	=S-T

Appendix II: Store Count by State

List of Store Count by State - 2005				Average Sales Per Store ($ Mil.)			
				5.43	4.40	3.28	
		Store Count			Sales-Adjusted Store Count Share		
STATE	WAG (Blue)	CVS (Red)	RAD (Green)	WAG (Blue)	CVS (Red)	RAD (Green)	Map Color
Alabama	46	143	110	20.1%	50.8%	29.1%	Red
Arizona	215	58		82.0%	18.0%	0.0%	Blue
Arkansas	28			100.0%	0.0%	0.0%	Blue
California	408	371	588	38.3%	28.3%	33.4%	Swing
Colorado	101		25	87.0%	0.0%	13.0%	Blue
Connecticut	52	132	35	28.8%	59.4%	11.7%	Red
Delaware		2	24	0.0%	10.0%	90.0%	Green
District of Columbia		48	8	0.0%	88.9%	11.1%	Red
Florida	653	653		55.2%	44.8%	0.0%	Blue
Georgia	96	271	47	27.9%	63.9%	8.3%	Red
Idaho	17		19	59.7%	0.0%	40.3%	Blue
Illinois	486	138		81.3%	18.7%	0.0%	Blue
Indiana	152	244	9	42.8%	55.7%	1.5%	Red
Iowa	54			100.0%	0.0%	0.0%	Blue
Kansas	47	12		82.8%	17.2%	0.0%	Blue
Kentucky	59	56	116	33.8%	26.0%	40.2%	Swing
Louisiana	102	84	68	48.3%	32.3%	19.5%	Swing
Maine		17	79	0.0%	22.4%	77.6%	Green
Maryland	18	166	133	7.7%	57.8%	34.5%	Red
Massachusetts	106	313		29.4%	70.6%	0.0%	Red
Michigan	165	228	317	30.5%	34.1%	35.4%	Swing
Minnesota	98	15		89.0%	11.0%	0.0%	Blue
Mississippi	37	29	28	47.8%	30.4%	21.9%	Swing
Missouri	144	18		90.8%	9.2%	0.0%	Blue
Montana	2			100.0%	0.0%	0.0%	Blue
Nebraska	43		36	66.4%	0.0%	33.6%	Blue
Nevada	55	23		74.7%	25.3%	0.0%	Blue
New Hampshire	11	27	38	19.7%	39.2%	41.1%	Swing
New Jersey	82	245	156	21.9%	53.0%	25.2%	Red
New Mexico	50			100.0%	0.0%	0.0%	Blue
New York	69	421	383	10.7%	53.2%	36.1%	Swing
North Carolina	75	270		25.5%	74.5%	0.0%	Red
North Dakota	1			100.0%	0.0%	0.0%	Blue
Ohio	173	308	236	30.6%	44.2%	25.2%	Swing
Oklahoma	68	33		71.8%	28.2%	0.0%	Blue
Oregon	37		71	46.3%	0.0%	53.7%	Swing

Note: California total for CVS includes 350 Save-On stores acquired in 2006
Sources: 10-K's for Store Concentration and Ave Sales Per Store

List of Store Count by State - 2005					Average Sales Per Store ($ Mil.)		
					5.43	4.40	3.28
	Store Count			Sales-Adjusted Store Count Share			
STATE	WAG (Blue)	CVS (Red)	RAD (Green)	WAG (Blue)	CVS (Red)	RAD (Green)	Map Color
Pennsylvania	43	354	348	8.0%	53.1%	38.9%	Red
Puerto Rico	63			100.0%	0.0%	0.0%	Blue
Rhode Island	16	52		27.5%	72.5%	0.0%	Red
South Carolina	42	174		22.9%	77.1%	0.0%	Red
South Dakota	6			100.0%	0.0%	0.0%	Blue
Tennessee	181	123	47	58.5%	32.3%	9.2%	Blue
Texas	511	461		57.7%	42.3%	0.0%	Blue
Utah	24		24	62.3%	0.0%	37.7%	Blue
Vermont	2	2	12	18.4%	14.9%	66.7%	Green
Virginia	54	231	133	16.8%	58.2%	25.0%	Red
Washington	90		131	53.2%	0.0%	46.8%	Swing
West Virginia		48	102	0.0%	38.7%	61.3%	Green
Wisconsin	166			100.0%	0.0%	0.0%	Blue
Wyoming	5			100.0%	0.0%	0.0%	Blue
Total	4953	5770	3323				

Note: California total for CVS includes 350 Sav-On stores acquired in 2006

Sources: 10-K's for Store Concentration and Ave Sales Per Store