Industry Note

United States

Health Care Policy

Medicare's $400B Private Offering: New Drug Benefit and Managed Care

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SUMMARY

- Medicare, which accounts for 17% of U.S. health spending, will become a major payer of prescription drugs Jan. 1 and provide new incentives for its nearly 43 million elderly and disabled enrollees to get all their health benefits from managed-care health plans.
- Managed-care plans, which will begin enrolling new beneficiaries Nov. 15, will likely grow their Medicare Advantage business by more 1 million members, or 17%, next year and double to 24% penetration by 2009.
- Implications for most healthcare product and service companies. See companion note by George Grofik: Drugmakers benefit modestly overall from the drug benefit due to near-term volume gains, but future pricing risks longer-term will likely mitigate if not eliminate the sales benefit.
- We think President Bush and the Republican-controlled Congress are committed to ensuring attractive payment and rules for managed-care plans.

OPINION

The Republican-controlled Congress and President Bush created the redesigned and expanded Medicare program through the Medicare Modernization Act, (MMA) which was signed into law by Bush on Dec. 8, 2003.

The drug benefit, including low-income subsidies and transitional assistance, will cost taxpayers and beneficiaries $822 billion from 2006 through 2015, according to the Congressional Budget Office (CBO), Congress's chief budget estimator. In the first year of the benefit, Medicare and beneficiaries will pay $47.4 billion for drug coverage, the CBO estimated last March.

That's about 19% of the projected $249.3 billion in U.S. retail drug spending for 2006, according to the Medicare office the actuary.

In August, however, the Bush Administration announced that the benchmark drug premiums charged to Medicare beneficiaries are lower than originally expected, reducing the cost to the government of the program. In addition, CBO assumes about 87%, or 37 million, beneficiaries will enroll in the Medicare drug benefit by the end of 2006 – eight million more than our mid-range estimate.

To be sure, not all of the Medicare drug spending will be new. Large chunks of it are money on drug benefits currently being spent by Medicaid for the poor or employer retiree drug insurance. Medicare payments include subsidies to employers to continue to provide retiree drug benefits that are equal to or better than the new Medicare drug benefit. Still, the significant point is that Medicare will become a large payer of drug benefits in 2006 and its

share of U.S., drug spending will continue to grow. Medicare beneficiaries made up nearly 15% of the U.S. population in 1999, but accounted for about 40% of U.S. drug spending, according to the CBO.

That makes the implementation of the Medicare benefit critical to pharmacy benefit managers (PBMs), managed-care insurers, drugmakers and other segments of industry with a stake in elderly spending on drugs. We believe drugmakers, managed-care health plans and PBMs recognize that Medicare represents a major new business opportunity.

Thus, the plans and drugmakers seem more concerned with ensuring that they gain market share in the first year of the benefit than with growing their profit margins. In fact, the health plans bid lower than expected to provide drug benefits.

Total average payment to the plans for the prescription drug benefit (including reinsurance and beneficiary premiums) will be about 14% lower than expected by the government. That suggests the plans may give up some profit margin in the first year in exchange for growing their market share and/or that drugmakers are providing higher-than-expected concessions on price to drug insurance plans. It also suggests that several plans may not survive past the first year while others will seek a sharp boost in premiums for 2007 to cover costs they are willing to absorb in 2006 to gain market share.

Over the next two weeks, Medicare and the health plans will release additional information on drug formularies, cost sharing and prior authorization requirements that will help determine the business rationale for the wide range of drug insurance premiums.

Plans may have also taken additional steps to guard against losses due to higher-than-anticipated utilization. We understand that Medco (MHS, Not Rated) has structured its contracts with drugmakers to make the manufacturers assume some risk for over-utilization of drugs in the PBM's Medicare prescription drug plans. If a class is over-utilized, the manufacturers under contract to provide drugs in that class must pay additional rebates to Medco. If drug use in a class comes in below the utilization target, Medco will receive credit from the manufacturers for future transactions. This shows that the drugmakers are willing to reduce their profit to win a place on Medco's Medicare prescription drug plan formulary, creating or ensuring continued brand loyalty among senior citizens.

The U.S. drug-spending shift under the Medicare drug benefit will create new winners and losers in the drug industry and also among the major PBMs.

In addition, the privatization of Medicare represents an opportunity for managed-care plans to significantly expand their share of the $400-billion-a-year (includes drug benefit) Medicare program in 2006 and subsequent years. The percentage of Medicare beneficiaries enrolled in managed care health insurance will grow to 24% to 25% by the end of 2009 from about 14% now, according to Citigroup Investment Research projections. For 2006, we project Medicare enrollment in managed care will grow by more than 1 million, or 17%.

Medicare managed-care revenue for medical benefits other than outpatient prescription drugs is projected to rise to $49.4 billion in 2006 from $44.4 billion this year, according to the CBO. Medicare managed care revenue will rise to $105.2 billion by 2015, according to the CBO. In comparison, private health insurance currently finances $691 billion, or 36%, of U.S. health spending.

The privatization of Medicare represents the largest U.S. growth opportunity for managed-care health insurance plans. We think President Bush and the Republican-controlled Congress are committed to ensuring attractive payment and rules for managed-care plans. Over the next three years the plans must succeed at attracting beneficiaries and controlling costs to insulate them against the possibility of a change to a less friendly presidency in 2009.

The privatization of Medicare will potentially affect utilization and payments to hospitals and other providers of health services. As managed care companies gain market share among the elderly and disabled, their bargaining power with hospitals and other providers will grow. At the same time, the pending retirement of the baby boom generation starting in 2011 will increase pressure on Congress and the Executive Branch to cut the growth of Medicare and Medicaid, the health insurance program for the poor. We expect Congress and the next President to consider sharply cutting the growth of Medicare and Medicaid spending starting in 2009.

The fiscal challenges faced by the U.S. government may prove a double-edged sword for Managed Care. On the one hand we believe the government is expediting the migration into private Managed Care organizations because they can provide higher quality outcomes at a lower cost than the government run Part A and Part B plans can. However, the government may look to save even more money down the road by cutting the growth in reimbursement to Managed Care. We do not believe they will kill the geese laying the golden eggs. However, we do not believe they will support the roughly 5% profit margins (pre-tax) enjoyed today by the best run Medicare Advantage plans long-term. Near-term, at least for 2006-2007, we expect reimbursement to remain accommodating during the initial rollout of Part D.

The migration of seniors into an MA plan may reduce demand and increase price competition for the provider of healthcare services and the manufacturers of healthcare products.

To manage unit prices, health plans trade volume for price and offer incentives for members to seek high quality care at the lowest cost setting. In other words, the private sector relies on free market negotiations and switching providers or manufactures to achieve a lower unit price. The government on the other hand fixes prices, thereby supporting tremendous inefficiencies. For example, it is common to find manufacturers of products with good substitutes earning very high marginal returns in healthcare.

To manage demand, private health plans such as Humana and UnitedHealth Group employ many techniques unique to the private sector aimed at providing better outcomes at a lower cost than the government-run Part A hospital insurance and Part B outpatient insurance. For example, private health plans are free to eliminate or effectively “fire” physicians that don’t meet health plan criteria for quality or cost, including those known to order medically unnecessary tests, even if to protect themselves from malpractice lawsuits. Health plans may also require prior authorization before certain procedures that are subject to fraud and abuse. The government on the other hand allows physicians free and virtually unsupervised rein over medical decisions. Because physicians in the U.S. profit from each procedure they perform rather than for outcomes or on a salary basis, some physicians have been found to perform procedures that are medically unnecessary and even harmful to the patient in order to receive payment. The government doesn’t generally discover and discipline that behavior except in egregious

cases. While the government is working deliberately to incorporate some of the private sector techniques such as paying for quality, the bigger picture we believe is that this Administration and Congress believes the private sector will provide tax payers with more utility for their tax dollar and save money in the long run by privatizing Medicare.

MEDICARE HISTORY: THE ROAD TO THE DRUG BENEFIT AND PRIVATIZATION

Medicare Basics

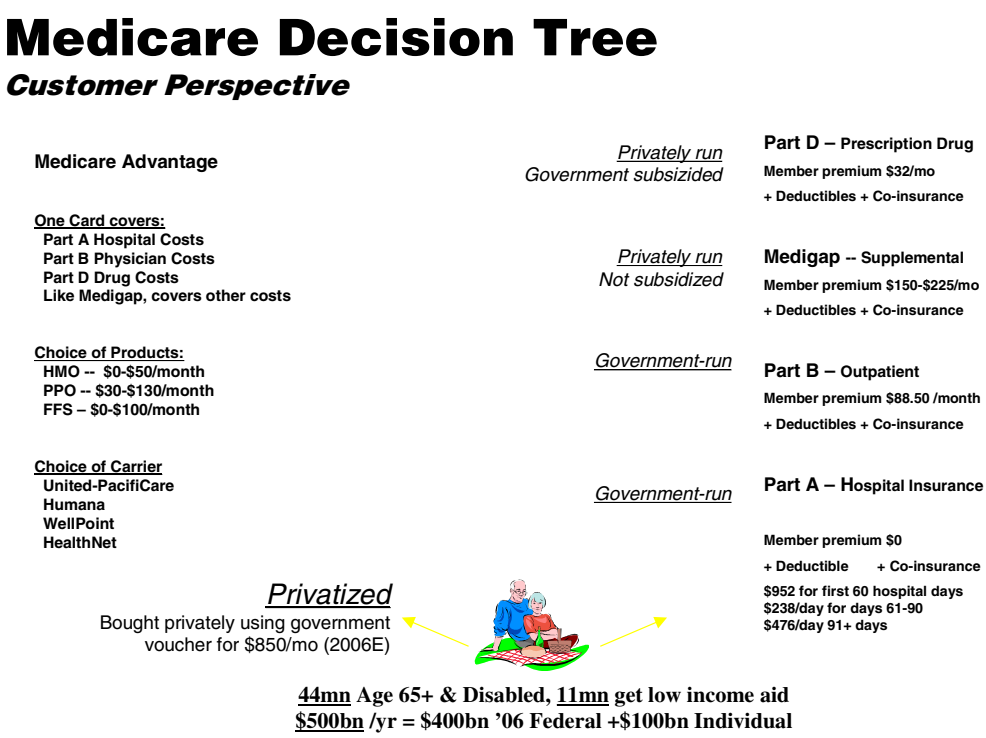
President Lyndon Johnson signed Medicare into law in July 1965, and the program began July 1, 1966. Medicare is divided into two parts:

- **Part A** covers overnight or inpatient hospital stays and skilled nursing facility, hospice and some home care. It is financed primarily by a 2.9% payroll tax split between employers and employees.
- **Part B** covers physician visits and other outpatient services, including home health care, durable medical equipment such as home oxygen, end-stage renal disease care in freestanding facilities, laboratory testing and outpatient hospital care. General taxpayer revenue finances 75% of Part B and Medicare enrollees pay the other 25% through a monthly premium deducted from their Social Security checks. The current monthly premium is $78.20. For next year, it is scheduled to rise 13% to $88.50 on Jan. 1.

Excluding home nursing care, Medicare part A accounts for about 45% of program spending. and part B for 35% of program spending. Home nursing care garners about 5% of Medicare spending. About 15% is paid to managed care, known as Medicare Part C. Hospital care (both inpatient and outpatient) draws 44% of Medicare spending, followed by reimbursement to physicians, which is about 18% of Medicare spending.

Over the first 40 years of the program, Medicare has moved from paying hospitals, physicians, nursing homes and other providers based on their reasonable costs to pricing formulas designed to discourage unnecessary costs in caring for a patient.

Figure 1: Medicare Decision Tree



Source: Citigroup Investment Research

The Single Medicare Advantage Card Verses Multiple Coverage Sources

About 37 million Medicare beneficiaries get their benefits through the traditional government-run fee-for-service program. About 6 million receive their health benefits through managed-care health insurers in the Medicare Advantage program, known as Medicare Part C. Medicare pays the plans a fixed fee per patient of approximately $728 a month to provide health benefits to the elderly, per our estimates for 2005E.

Beginning Jan. 1, Medicare beneficiaries will be able to sign up for a voluntary Medicare drug benefit, known as Medicare Part D. They will get their drug benefit through either a prescription drug only private insurance plan (PDP) if they choose to continue to get the rest of their benefits through traditional government Medicare or through a Medicare Advantage plan offering drug and other medical benefits.

Ten companies are offering prescription drug only plans nationally. Others are providing coverage in one or more of 34 regions created by Medicare. Some Medicare beneficiaries have as many as 40 to 50 choices of plans.

Beneficiaries in the traditional program will continue with their Medicare hospitalization coverage (part A) and pay the $88.50 premium in 2006 out of their monthly Social Security check for part B doctor care. They will also pay from their Social Security check the premium for a prescription drug only plan. As many as 10 million will also pay for commercial supplemental coverage (known as Medigap) to cover various Medicare out-of-pocket costs. Medicare patients in the traditional program next year will pay a $952 inpatient hospitalization deductible for part A care and a $124 deductible for part B.

As the diagram above shows, beneficiaries may also sign up to get all their benefits through a managed-care plan, with some or all of their part B premiums going to the plan. They can do so at the county level or through preferred-provider managed-care plans (PPO) offering drug and other benefits in one of 26 regions. The law requires these plans to offer a single part A/B deductible and to cover catastrophic costs – a protection that doesn't exist in traditional Medicare.

The Bush Administration estimates that a beneficiary in a Medicare Advantage program currently saves an average of $100 a month in lower out-of-pocket costs in comparison to what he or she would have paid under Medicare. The tradeoff for the patient care is narrower choice of physicians and other health providers. Beneficiaries signing up for a preferred-provider managed care plan would get a broad choice of doctors, but would pay more to see a doctor out of the a plan's network of physicians.

The many choices of drug coverage may provide incentive for some beneficiaries to collapse their health coverage into a single Medicare Advantage plan covering their drug and other benefits.

For 2006, Citigroup Investment Research estimates that Medicare Advantage plans will add more than 1 million customers at an average of $812 per member per month. **That includes the new drug benefit payment.** Based on the average premium of $32.20 a month, the government and elderly will pay $92.30 per member per month ($126.28 when including estimated catastrophic coverage reinsurance) to provide drug benefits. Managed-care plans in 44 states, however, are offering drug benefits with zero premiums. Further, prescription drug only insurance plans for under $20 a month will be available in every state except Alaska.

Figure 2: Part D Benchmark

Avg. Plan Bid:

Nat. Avg. Bid	(Bene. Prem. + Direct Subsidy)	$ 92.30	
Reinsurance		$ 33.98	
D PMPM Cashflow		$ 126.28	

Statutory Split:

Beneficiary Premium	(25.5% of D PMPM)	$ 32.20	25.5%
Federal Contribution	(74.5% of D PMPM)	$ 94.08	74.5%
D PMPM Cashflow	(Nat. Avg. Bid + Reinsurance)	$ 126.28	100.0%

Premium Revenue:

Direct Subsidy	(Nat. Avg. Bid - Bene. Prem.)	$ 60.10
Beneficiary Premium	(25.5% of D PMPM)	$ 32.20
Total Premium to Plan (at risk)		$ 92.30

Source: Citigroup Investment Research and CMS

Medicare Managed Care History and the Start of Privatization

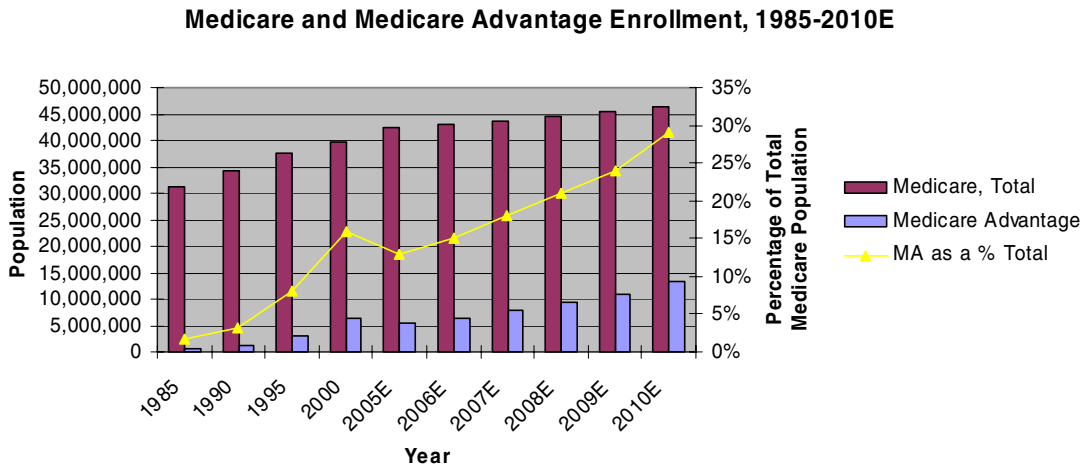
The federal government turned to managed care to help control Medicare spending growth early in the program's history. A key catalyst for growth of Medicare managed care came in 1982 with Congressional passage of a law that allowed Medicare to pay HMOs a fixed fee that equaled 95% of the average cost of care for Medicare beneficiary. The plans were at risk of losing money if the cost of caring for the patient exceeded the fixed payment.

The law did not take effect until 1985. Enrollment by Medicare beneficiaries grew to 1.4 million beneficiaries by the end of 1991.

The second catalyst for growth came with the focus on HMOs as a way to control rising health-care costs during the early and mid 1990s. Average Medicare HMO payment rates rose as high as 8% a year per-enrollee during the mid-1990s at a time when health inflation had slowed drastically. That left money for the plans to provide extra benefits to attract beneficiaries, By 1997, 96% of Medicare beneficiaries in an HMO had drug coverage through their health plans. Medicare HMO participation peaked at 6.4 million, or 17% of Medicare enrollees in 1999.

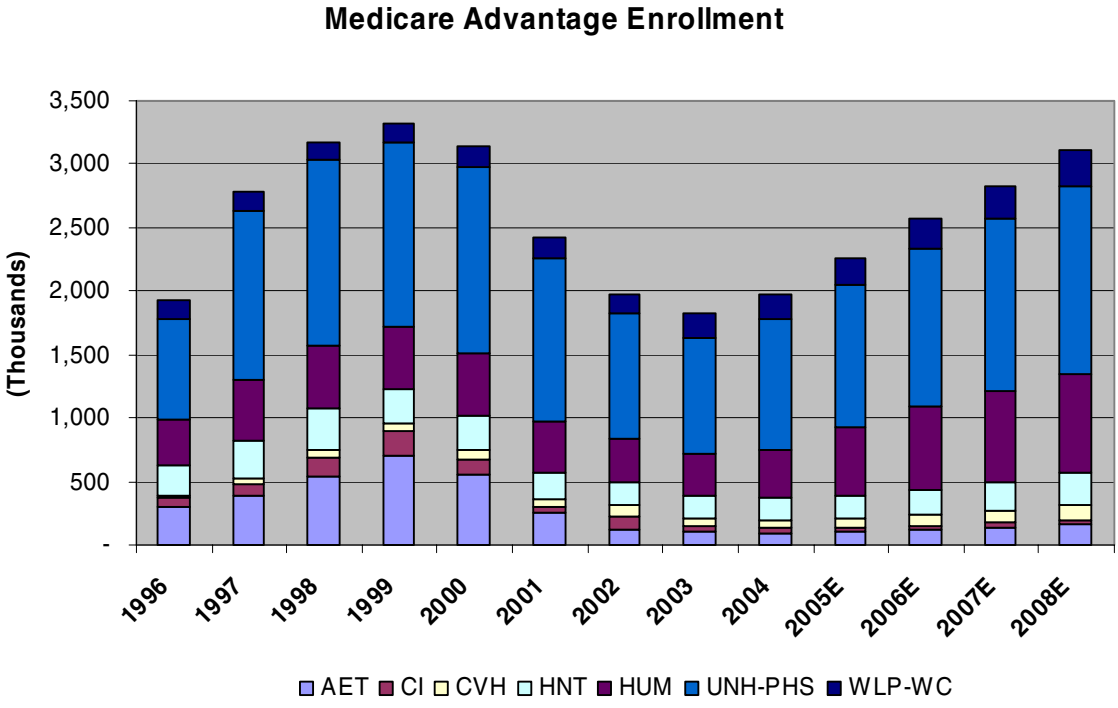
Enrollment then declined over the next few years as a result of a 2% cap on Medicare payment growth in many counties included in the 1997 Balanced Budget law. In 2003, Medicare enrollment in Medicare managed care plans hit a low of 4.6 million, 12% of Medicare beneficiaries.

Figure 3: Medicare and Medicare Advantage Enrollment, 1985-2010E



Sources: Medicare Trustees Report (2005), Kaiser Family Foundation, CMS, CIR Estimates

Figure 4: Medicare Advantage Enrollment for Coverage Universe



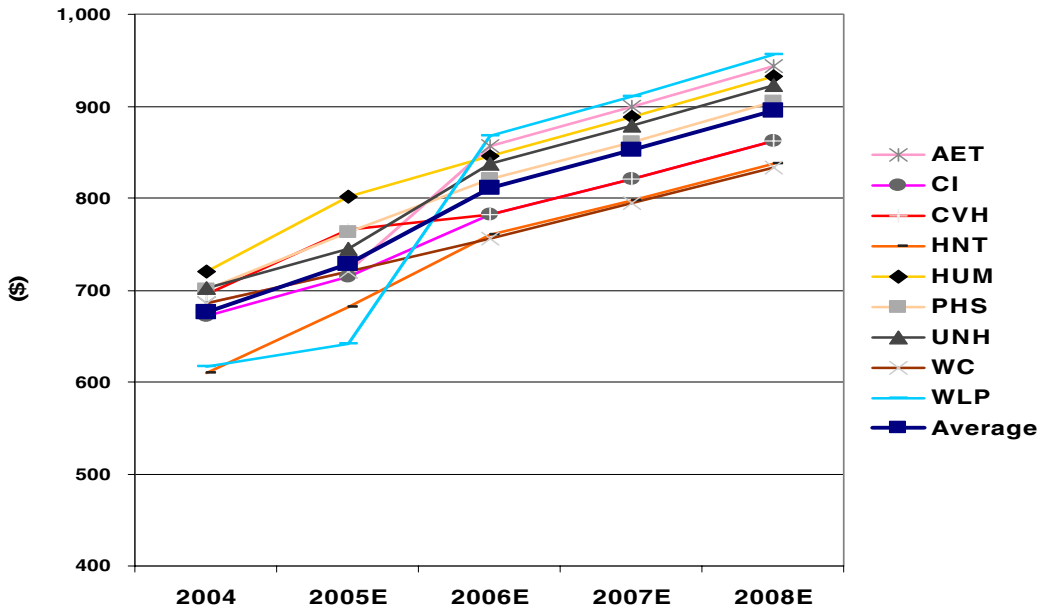
Source: Citigroup Investment Research

The Medicare Modernization Act renamed the managed-care program Medicare Advantage from Medicare+Choice and significantly increased payment. The payment formula was revised to pay a minimum of 100% of the average cost of a Medicare fee-

for-service patient in a county. The law also folded teaching hospital spending into the rates. As a result, Medicare Advantage payment rose a minimum of 6.6% this year and significantly more in some counties. Reimbursement is scheduled to increase almost 5% next year.

The Medicare Payment Advisory Commission, an advisory panel to Congress, estimates that Medicare is actually paying plans an average of 107% of local fee-for-service cost of care. In its June report, the commission argued that Medicare is paying health plans twice for teaching hospital care, once through fixed payment rate per-person that Medicare makes to health plans and also through separate teaching hospital rates made to hospitals on behalf of the plans.

Figure 5: Medicare Advantage Revenue Per Member Per Month



Source: Citigroup Investment Research

Currently, any drug benefit health plans provide to the elderly comes out of the fixed per-patient rate the plans receive for other medical care. Beginning Jan. 1, the plans will get a separate estimated government/beneficiary payment – $126.28 per member per month (including estimated reinsurance payments for catastrophic costs) – to provide drug benefits. The payments will vary based on the amount of government reinsurance payment required by the plans to cover catastrophic coverage and by the level of premium charged to the enrollee.

The Medicare Modernization Act payment revisions have reversed the decline in Medicare managed-care enrollment. Medicare managed-care enrollment rose to 5.9 million in August from 4.6 million in 2003, according to data from the Medicare Payment Advisory Commission and the Kaiser Family Foundation, a non-profit research group unaffiliated with Kaiser health plans.

We believe Congress and the Bush Administration has structured the drug benefit and the Medicare Advantage program to encourage enrollment in managed care and to ensure a financing stream to help it succeed.

On the drug benefit, the Medicare Modernization Act and Bush Administration regulations insulate health plans and PBMs from some of the risk of providing drug benefits to the elderly.

We believe risk adjustment, risk corridors and reinsurance payments provide protection for Medicare Advantage and drug insurance only plans to enroll sicker patients. Congress through the Medicare Modernization Act and the Centers for Medicare and Medicaid Services (CMS) built in three layers of protection for the drug benefit.

- **Reinsurance:** The government picks up 80% of a plan's catastrophic costs after the coverage is triggered when a patient spends $3,600 out-of-pocket on drugs. Under the standard benefit design, that means catastrophic coverage would kick in at $5,100 in total drug spending.

- **Risk adjustment:** Medicare will adjust payments upward for, among others, low-income beneficiaries and for beneficiaries in nursing homes. Medicare officials have said payments to plans to cover low-income or nursing home patients with a number of co-morbidities could be significantly higher than standard rates –50% or greater.

- **Risk corridors:** The government will help cover a plan's losses if they exceed 2.5% of its spending target. A plan's spending target equals the prepayments by the government through direct subsidies and the beneficiary through premiums for basic benefit drug expenses. The government covers 75% of the second 2.5% of losses above the spending target and then 80% of any additional losses. The law, however, requires plans to share an equivalent amount of profits in excess of 2.5%.

Still, the Bush Administration has also said plans can wall off profits and administrative expenses built into its accepted bid from the risk corridor arrangement. So if a plan has a 5% profit margin and a 10% cushion for administrative expenses built into its bid, the government would only reclaim 75% or more of the profits in excess of 17.5%.

In addition, CMS officials have said they will rely heavily on the plans in the first year to estimate what level of reinsurance payments should be built into the bid. The difference between actual reinsurance costs during the year and the upfront payments will be reconciled in 2007 by the government and the health plans. These up front payments in 2006 should help ensure, at the every least, that plans have adequate cash flow to cover expensive cases. The risk to investors is that some of the 2006 EPS and cash flow reported may be clawed back by the government the following year. The CMS has estimated the reinsurance payments at $33.98 per member per month, a portion of the estimated $126.28 per-member, per-month payment for the drug benefit.

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Figure 6: Medicare Advantage EPS Contribution

MEDICARE ADVANTAGE EPS CONTRIBUTION (05E-08E)										
		AET	CI	CVH	HNT	HUM	PHS	UNH	WC	WLP
Enrollment (000)	2004	97	33	69	171	377	705	330	56	140
	2005E	**103**	**33**	**76**	**176**	**546**	**745**	**368**	**64**	**144**
	2006E	172	41	103	243	762	942	529	79	250
	2007E	181	43	109	255	800	989	555	83	262
	2008E	190	46	114	268	840	1,038	583	87	276
Medicare Advantage	2004	686	672	696	610	721	700	702	686	616
Premium PMPM ($)	**2005E**	**720**	**715**	**766**	**682**	**802**	**762**	**745**	**720**	**641**
	2006E	856	781	782	760	846	820	837	756	867
	2007E	899	821	821	798	888	861	879	794	911
	2008E	944	862	862	838	932	904	923	833	956
Medicare Advantage	2004	$798	$266	$576	$1,254	$3,262	$5,922	$2,781	$461	$1,035
Revenue	**2005E**	**$863**	**$284**	**$666**	**$1,422**	**$4,441**	**$6,630**	**$3,121**	**$518**	**$1,094**
($mil)	2006E	$1,412	$350	$841	$1,913	$6,637	$8,301	$4,504	$649	$2,052
	2007E	$1,904	$417	$1,044	$2,388	$8,326	$9,977	$5,716	$771	$2,799
	2008E	$2,099	$460	$1,151	$2,632	$9,180	$11,000	$6,301	$850	$3,086
Part D Start-Up ($mil)	**2005E**	**$50**	**$40**	**$10**	**$33**	**$80**	**$50**	**$75**	**$5**	**$30**
Medicare Advantage	2004	$40	$13	$29	$63	$163	$296	$139	$23	$52
Pretax Earnings	**2005E**	**$43**	**$14**	**$33**	**$71**	**$222**	**$331**	**$156**	**$26**	**$55**
($mil)	2006E	$71	$18	$42	$96	$299	$397	$225	$28	$103
	2007E	$95	$21	$52	$119	$416	$499	$286	$39	$140
	2008E	$105	$23	$58	$132	$459	$550	$315	$43	$154
Pre-Tax Margin Assumption	**2004-08E**	**5%**	**5%**	**5%**	**5%**	**5%**	**5%**	**5%**	**5%**	**5%**
Tax rate	2004	35.8%	35.9%	36.0%	39.2%	33.8%	38.6%	35.2%	37.9%	37.7%
	2005E	**35.6%**	**34.9%**	**37.2%**	**38.7%**	**33.9%**	**38.7%**	**35.5%**	**38.0%**	**37.3%**
	2006E	35.3%	36.2%	37.1%	38.0%	34.0%	38.8%	35.5%	38.0%	37.0%
	2007E	35.4%	36.6%	37.0%	38.0%	34.0%	38.8%	35.5%	38.0%	37.0%
	2008E	34.9%	36.7%	37.0%	38.0%	34.0%	38.8%	35.5%	38.0%	37.0%
Medicare Advantage	2004	$26	$9	$18	$38	$108	$182	$90	$14	$32
After Tax Earnings	**2005E**	**$28**	**$9**	**$21**	**$44**	**$147**	**$203**	**$101**	**$16**	**$34**
($mil)	2006E	$46	$11	$26	$59	$197	$243	$145	$17	$65
	2007E	$61	$13	$33	$74	$275	$305	$184	$24	$88
	2008E	$68	$15	$36	$82	$303	$337	$203	$26	$97
Shares	2004	315.6	137.9	90.6	113.0	162.5	95.1	1305.3	83.8	616.8
Outstanding (mil)	**2005E**	**304.2**	**129.7**	**108.2**	**115.0**	**165.5**	**98.2**	**1315.5**	**84.8**	**623.5**
	2006E	304.1	120.2	111.1	115.8	166.0	97.5	1296.5	82.6	664.7
	2007E	298.1	112.7	109.7	116.0	166.0	96.2	1297.5	80.7	660.3
	2008E	295.9	105.9	108.9	116.3	166.0	94.4	1298.5	79.9	655.9
Medicare Advantage EPS	2004	$0.08	$0.06	$0.20	$0.34	$0.66	$1.91	$0.07	$0.17	$0.05
	2005E	**$0.09**	**$0.07**	**$0.19**	**$0.38**	**$0.89**	**$2.07**	**$0.08**	**$0.19**	**$0.05**
	2006E	$0.15	$0.09	$0.24	$0.51	$1.19	$2.49	$0.11	$0.21	$0.10
	2007E	$0.21	$0.12	$0.30	$0.64	$1.66	$3.17	$0.14	$0.30	$0.13
	2008E	$0.23	$0.14	$0.33	$0.70	$1.82	$3.57	$0.16	$0.33	$0.15
Y-Y Growth in	2005E	13%	16%	-5%	12%	34%	8%	11%	11%	5%
Medicare Advantage EPS	**2006E**	**64%**	**30%**	**23%**	**35%**	**34%**	**20%**	**46%**	**11%**	**77%**
	2007E	37%	26%	26%	25%	39%	27%	27%	42%	37%
	2008E	12%	17%	11%	10%	10%	12%	10%	11%	11%
EPS-Company total	2004	$3.51	$7.71	$3.72	$1.83	$1.68	$3.23	$1.97	$2.87	$3.32
	2005E	**$4.60**	**$7.45**	**$4.75**	**$2.50**	**$2.16**	**$3.61**	**$2.47**	**$3.39**	**$4.01**
	2006E	$5.50	$8.40	$5.65	$3.20	$2.90	$4.75	$3.05	$4.30	$4.95
	2007E	$6.30	$9.25	$6.45	$3.75	$3.50	$5.55	$3.55	$4.90	$5.80
	2008E	$7.15	$10.15	$7.20	$4.30	$4.10	$6.35	$4.05	$5.40	$6.80
Conribution to EPS from	2004	2.3%	0.8%	5.5%	18.4%	39.5%	59.3%	3.5%	5.9%	1.6%
Medicare Advantage	**2005E**	**2.0%**	**1.0%**	**4.1%**	**15.1%**	**41.1%**	**57.4%**	**3.1%**	**5.6%**	**1.4%**
	2006E	2.7%	1.1%	4.2%	16.0%	41.0%	52.4%	3.7%	4.9%	2.0%
	2007E	3.3%	1.3%	4.6%	17.0%	47.3%	57.2%	4.0%	6.1%	2.3%
	2008E	3.2%	1.4%	4.6%	16.3%	44.5%	56.2%	3.9%	6.1%	2.2%
	2005E	0.2%	0.1%	-0.2%	1.7%	10.3%	4.3%	0.3%	0.6%	0.1%
Contribution to EPS Growth of	**2006E**	**1.1%**	**0.3%**	**0.8%**	**4.2%**	**10.4%**	**8.9%**	**1.2%**	**0.5%**	**0.9%**
Medicare Advantage	2007E	0.9%	0.3%	0.9%	3.4%	13.4%	12.3%	0.8%	1.8%	0.6%
	2008E	0.3%	0.2%	0.5%	1.5%	4.1%	6.2%	0.4%	0.6%	0.2%
Medicare Advantage	2004	$21.14	$18.93	$22.92	$18.51	$25.49	$21.85	$26.81	$22.48	$18.85
After-Tax Profit PMPM	**2005E (A)**	**(3.68)**	**(42.17)**	**16.82**	**11.35**	**16.97**	**19.84**	**12.48**	**18.01**	**9.07**
	2005E P-F (A)	**$23.19**	**$23.27**	**$24.03**	**$20.90**	**$26.52**	**$23.37**	**$24.03**	**$22.32**	**$20.09**
	2006E	$27.67	$24.93	$24.60	$23.55	$25.12	$23.99	$26.99	$20.15	$27.32
	2007E	$29.02	$26.02	$25.84	$24.73	$29.30	$26.35	$28.34	$24.61	$28.68
	2008E	$30.70	$27.27	$27.14	$25.97	$30.77	$27.67	$29.76	$25.84	$30.12
Y-Y Growth in	2005E P-F (A)	9.7%	22.9%	4.8%	12.9%	4.1%	6.9%	-10.4%	-0.7%	6.6%
Med Advantage	**2006E (A)**	**NA**	**NA**	**46.3%**	**107.6%**	**48.0%**	**20.9%**	**116.3%**	**11.9%**	**201.2%**
After-Tax Profit PMPM	**2006E P-F (A)**	**19.3%**	**7.2%**	**2.4%**	**12.7%**	**-5.3%**	**2.7%**	**12.3%**	**-9.7%**	**36.0%**
	2007E	4.9%	4.3%	5.1%	5.0%	16.7%	9.8%	5.0%	22.1%	5.0%
	2008E	5.8%	4.8%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

P-F=Pro Forma

Footnote (A) 2005E after-tax profit includes expenses related to 2006 Part D and other initiatives. The 2005E pro forma row excludes those expenses.
Source: Company reports, CIR Estimates

Medicare Advantage bidding

Managed care plans will bid locally against a benchmark that is based on the annual payment formula used to set rates around the country from medical benefits other than drug coverage. If a plan bids below the benchmark amount, the government gets 25% of difference between the bid and the benchmark and the plan gets the other 75%. That money must be used by the plans to improve the benefits package, either by reducing out-of-pocket costs or enhancing the benefits package

We see this as an opportunity for plans to reduce or eliminate the drug benefit premium. By doing so, we think the plans will be able to draw elderly patients out of traditional Medicare. The prescription drug only health plans, which will offer medicine coverage to beneficiaries who decide to stay in traditional fee-for-service Medicare, don't have the same opportunity to reduce premiums, other than by bidding to provide drug benefits below the benchmark drug reimbursement rate.

Thus, a Medicare Advantage plan can bid to provide drug benefits at a higher rate than the average bid, and use money from bidding below the benchmark on non-drug benefits to eliminate any extra premium that a beneficiary would pay for a higher-than-average drug bid. This allows a health plan to offer a more generous benefit at a lower cost to the beneficiary than a prescription drug only plan. Medicare Advantage managed-care plans in 44 states will offer a drug benefit at no additional cost next year, according to CMS.

In addition, managed care plans can contain costs by coordinating care among a broader set of medical benefits than just drug coverage. A drug insurance only plan doesn't gain from prescribing drugs that might reduce the need for a hospital stay.

CMS officials have also suggested a plan that may seek to provide relief to the elderly from some of the 2006 $88.50 monthly premium for the physician or part B portion of the Medicare program.

The structure of the Medicare Advantage bidding and the significant payments allow the plans to return to the strategy of offering better benefits and low premiums that helped attract Medicare beneficiaries into managed care during the mid 1990s.

We think health plans such as Humana will offer drug-only insurance to traditional Medicare enrollees as a vehicle to attract beneficiaries into their Medicare Advantage offering of comprehensive medical benefits. Humana, for example, will offer a prescription drug only plan in 46 states and the District of Columbia.

Medicare officials said in June that they have not established a single benchmark for how much profitability a managed-care plan can build into their bids – although profits in-line with a plan's commercial gains are probably okay. The CMS looked for statistical outliers on profitability when reviewing bids, which are now finalized. Why, for example, was a plan seeking a 10% profit in a market, when everyone else is building in 4%? A plan may be able to justify a higher profit than its commercial norm based on the risk it is taking in a certain market, the CMS said. Plans need to justify the higher profit request to the CMS.

Regional Medicare Preferred-Provider Organizations

The Medicare Modernization Act also created a framework for regional preferred-provider organizations (R-PPOs) to serve Medicare beneficiaries nationally or in one or more of 26 regions around the country. The R-PPO is a less attractive option for most health plans than the local HMO or local PPO, because of the challenges of building a physician and hospital network in rural areas and because the plans exert less control over targeting a healthier cohort of beneficiaries.

Congress and the Bush Administration have taken steps, nonetheless, to make the Medicare regional managed-care option more attractive.

To reduce risk to plans, the administration announced in December 2004 that Medicare would increase payments to plans to compensate them for enrollment in costly parts of a region. To be sure, Medicare will finance the payment adjustment by reducing reimbursement in areas of a region where costs are below average. Still, the Medicare business for publicly traded managed-care companies is concentrated in high-cost urban areas; so we would expect beneficiaries to identify most closely with, and sign up in higher numbers for, those plans in urban areas.

Responding to concerns that local rural hospitals would not participate in the regional preferred-provider networks, Medicare agreed to pay hospitals deemed essential more money if they can't reach a rate agreement with a regional preferred-provider organization. This is a modest benefit to managed care. It is only expected to affect a small number of hospitals, with $25 million set aside for these extra payments in 2006. In comparison, Medicare expects to spend $130 billion on hospital payment this year.

These plans must offer catastrophic coverage and drug benefits (for at least 1 regional plan per region), but are protected from downside risk. If a regional plan's allowable costs exceed 103% of government and beneficiary premium payments (minus administrative expenses and certain supplemental benefits) but are less than 108%, Medicare will cover 50% of the additional costs above 103%.

If the allowable costs to the plan are greater than 108%, Medicare will cover the first 2.5% of losses plus 80% of the losses above 108% of the government and beneficiary premium payments. In a symmetrical arrangement, the plans are required to share an equivalent amount of profits if their costs are less than 97% of Medicare payment and beneficiary premiums.

Like the local plans, the regional plans bid against a benchmark. However, the benchmark is a blend of the weighted average of Medicare Advantage payment rates in a region and the average plan bids in a region. For 2006, 87.4% of the regional benchmark is based on the regional weighted average of the county-by-county benchmarks that are created by formula. That formula sets benchmark rates at no less the average cost of treating a Medicare fee-for-service patient. The remainder of the benchmark will be set based on the weighted average of the regional bids. Given that the benchmark rate is skewed toward the county fee-for-service rates, we think the regional rates are generally positive for the health plans. They will average $741 per member per month next year, compared to the average county rate of $746 for 2005.

Humana will be a major provider of regional PPO network, providing coverage in 14 of 26 regions (23 states). Humana will most likely become one of the larger regional PPO players, especially given that PacifiCare and other Medicare players have not expressed an

interest in pursuing that market at this point. Health Net will offer a regional PPO in Arizona, where monthly per-member per-month payments will be $714.46; Aetna in the regions covering New Jersey, Maryland, Washington, DC and Delaware. Monthly reimbursement in the region covering Delaware, Maryland and Washington DC will be $769.61 and for the region covering New Jersey will be $789.26. WellPoint will participate in California, Indiana, Kentucky and Ohio, and UnitedHealth in Florida, Hawaii and New York.

Figure 7: Medicare Advantage Regional PPOs

						Weighting (1)						Weighting (2)		
		Statutory Component		Plan Bid Component		Statutory Component Weightings			Bid Plan Component Weightings			Statutory	Plan Bid	Regional
Reg	State(s)	Demgrphc	Risk	Demgrphc	Risk	25.0%	75.0%	Sum	25.0%	75.0%	Sum	87.4%	12.6%	Rate
1	ME, NH	$655.55	$703.71	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2	CT, MA, RI, VT	$733.75	$761.76	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
20	NM	$670.01	$728.55	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
23	ID, OR, UT, WA	$665.53	$715.21	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
26	AK	$718.29	$778.05	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
16	LA, MS	$758.63	$850.87	$828.64	$807.52	$189.66	$638.15	$827.81	$207.16	$605.64	$812.80	$723.51	$102.41	$825.92
17	TX	$743.30	$853.24	$796.26	$776.86	$185.83	$639.93	$825.76	$199.07	$582.65	$781.71	$721.71	$98.50	$820.21
3	NY	$813.85	$814.28	$686.29	$712.64	$203.46	$610.71	$814.17	$171.57	$534.48	$706.05	$711.59	$88.96	$800.55
4	NJ	$832.99	$780.63	$812.55	$740.20	$208.25	$585.47	$793.72	$203.14	$555.15	$758.29	$693.71	$95.54	$789.26
24	CA	$766.60	$801.58	$811.18	$740.83	$191.65	$601.19	$792.84	$202.80	$555.62	$758.42	$692.94	$95.56	$788.50
9	FL	$797.53	$776.90	$704.83	$684.65	$199.38	$582.68	$782.06	$176.21	$513.49	$689.70	$683.52	$86.90	$770.42
5	DE, DC, MD	$783.30	$775.14	$747.99	$706.80	$195.83	$581.36	$777.18	$187.00	$530.10	$717.10	$679.26	$90.35	$769.61
22	NV	$760.05	$755.93	$649.58	$667.14	$190.01	$566.95	$756.96	$162.40	$500.36	$662.75	$661.58	$83.51	$745.09
6	PA, WV	$748.18	$742.75	$794.39	$731.05	$187.05	$557.06	$744.11	$198.60	$548.29	$746.89	$650.35	$94.11	$744.46
11	MI	$749.35	$728.52	$747.41	$680.80	$187.34	$546.39	$733.73	$186.85	$510.60	$697.45	$641.28	$87.88	$729.16
18	KS, OK	$672.28	$738.95	$777.14	$771.64	$168.07	$554.21	$722.28	$194.29	$578.73	$773.02	$631.27	$97.40	$728.67
10	AL, TN	$679.96	$723.74	$756.83	$737.65	$169.99	$542.81	$712.80	$189.21	$553.24	$742.45	$622.98	$93.55	$716.53
21	AZ	$677.84	$726.89	$728.28	$708.33	$169.46	$545.17	$714.63	$182.07	$531.25	$713.32	$624.58	$89.88	$714.46
14	IL, WI	$686.28	$729.66	$685.15	$677.92	$171.57	$547.25	$718.82	$171.29	$508.44	$679.73	$628.24	$85.65	$713.89
12	OH	$691.32	$726.99	$689.40	$660.70	$172.83	$545.24	$718.07	$172.35	$495.53	$667.88	$627.60	$84.15	$711.75
15	AR, MO	$667.41	$717.83	$753.89	$737.99	$166.85	$538.37	$705.23	$188.47	$553.49	$741.97	$616.37	$93.49	$709.85
8	GA, SC	$677.14	$717.18	$680.45	$701.82	$169.29	$537.89	$707.17	$170.11	$526.37	$696.48	$618.07	$87.76	$705.82
13	IN, KY	$671.93	$716.31	$700.40	$675.17	$167.98	$537.23	$705.22	$175.10	$506.38	$681.48	$616.36	$85.87	$702.22
7	NC, VA	$667.93	$714.10	$694.27	$688.60	$166.98	$535.58	$702.56	$173.57	$516.45	$690.02	$614.04	$86.94	$700.98
25	HI	$669.67	$720.38	$659.94	$611.54	$167.42	$540.29	$707.70	$164.99	$458.66	$623.64	$618.53	$78.58	$697.11
19	IA, MN, MT, NE, ND, SD, WY	$644.33	$699.04	$656.31	$695.04	$161.08	$524.28	$685.36	$164.08	$521.28	$685.36	$599.01	$86.36	$685.36
	Simple Avg	$715.50	$749.93	$731.48	$710.23	$180.47	$564.68	$745.15	$182.87	$532.67	$715.55	$651.26	$90.16	$741.42

(1) Assumed weighting of demographic vs. risk, following county Medicare Advantage rates.
(2) Statutory vs. bid weighting for regional plans.
Source: Citigroup Investment Research and CMS

Like the local Medicare Advantage plans, the regional preferred provider plans will be paid separately to provide drug benefits. Unlike the local plans, the regional PPOs are required to provide catastrophic coverage for Medicare medical benefits, not just drug benefits (for at least 1 regional plan per region).

Congress also provided a $10 billion stabilization fund that the Secretary of Health and Human Services can tap in 2007 to encourage plans to participate in underserved regions. However, this fund may be vulnerable to elimination in Congress over the next few years. We don't see the elimination of this flow of money as a major threat to the success of the health plans in Medicare Advantage.

In addition, the Bush Administration announced in its fiscal 2006 budget released in February that it would phase in from 2007 through 2010 a revision to risk adjustment policies of Medicare Advantage plans that will reduce the growth of projected payments by several billion dollars during that period. Here again, the plans have been expecting this change and we don't see this as a major threat to the success of the plans.

We see some opportunity for managed-care plans to prosper under the Regional PPO arrangement. However, we think the far greater opportunity is at the local level.

The Drug Benefit and Enrollment

We believe that Congress and the Bush Administration have structured the drug benefit in a way that makes it attractive for pharmacy benefit managers (PBMs) such as Medco and for managed-care plans to participate.

The law and the administration's interpretation of law gives PBMs and managed-care plans many tools used in their commercial business to control costs, including tiered co-payments to encourage use of generic or preferred brands. At the same time, the model formulary guidelines are similar to the structure of formularies in commercial offerings. These formularies are a model – a safe harbor for plans when negotiating with the government to offer a drug benefit. Plans, however, can negotiate variations of the formulary when contracting with the government to offer a Medicare drug benefit.

We believe about 29 million, or 67%, of beneficiaries will get Medicare drug coverage in 2006, including about 9 million retirees who will continue to get coverage through their former employers. These numbers might be slightly lowered by the disruptions caused by Hurricane Katrina.

Figure 8: Part D EPS Contribution

	Part D - 2006E								
	AET	CI	CVH	HNT	HUM	PHS	UNH	WC	WLP
Enrollment, (000)	1,024	1019	1074	418	1501	1419	2,475	0	2,274
PMPM	$106	$104	$129	$210	$176	$168	$144	$0	$148
Revenue	$1,302.5	$1,271.7	$1,662.6	$1,053.4	$3,170.1	$2,860.7	$4,276.8	$0.0	$4,038.6
Pretax	$32.6	$30.5	$37.4	$22.1	$68.2	$62.9	$154.0	$0.0	$141.4
Pre-Tax Margin	2.5%	2.4%	2.3%	2.1%	2.2%	2.2%	3.6%	0.0%	3.5%
Tax Rate	35%	36%	37%	38%	34%	39%	36%	38%	37%
After Tax Profit ($mil)	$21.1	$19.5	$23.5	$13.7	$45.0	$38.5	$99.3	$0.0	$89.1
Share Count (Ths.)	304	120	111	116	166	98	1,297	83	621
EPS Impact - Modeled	$0.07	$0.16	$0.21	$0.12	$0.27	$0.39	$0.08	$0.00	$0.14
2006E Est-Company total	$5.50	$8.40	$5.65	$3.20	$2.90	$4.75	$3.05	$4.30	$4.95
Part D as % of EPS	1.3%	1.9%	3.7%	3.7%	9.4%	8.3%	2.5%	0.0%	2.9%
After-Tax Profit PMPM	$1.71	$1.59	$1.83	$2.73	$2.50	$2.26	$3.34	$0.00	$3.26

Source: Citigroup Investment Research and CMS

We think employers will largely continue to provide retiree coverage in 2006 as a result of political pressure and a government pre-tax employer subsidy of 28 cents per $1 of allowable enrollee prescription drug costs between $250 and $5,000.

We think Medicare will automatically enroll about 6.3 million elderly poor currently getting their drug coverage through Medicaid for the poor, the so-called dual eligibles.

Medicare enrollment in managed care stands at about 5.9 million. We think the health plans will have no trouble signing people up to get drug benefits, especially because many will likely be in plans that are able to subsidize most if not all of the premiums. In addition, we expect managed-care plans to sign up more than a million new beneficiaries for 2006.

Figure 9: Drug Coverage for 2005E and 2006E

Sources of drug coverage for Medicare beneficiaries	'05E Drug coverage sources	'06E Medicare or equivalent retiree drug coverage
Employer retiree coverage (Includes Federal Employees Health Benefits program)	12.7M	8.7M keep Medicare equivalent employer retiree drug coverage
		0.9M retired employees losing company coverage and signing up for drug benefit.
Medicaid dual eligibles	6.3M	6.3M
Managed care	5.9M	6.9M
No drug insurance (uninsured)	11M	4.5M
Medigap	1.4 M	0.6M
State drug assistance programs	1.2M	1.2M
Department of Veterans Affairs (VA)	2.1M	*
Department of Defense	1.4M	*
Total	42M**	29M

Source: Kaiser Family Foundation; CMS; Citigroup Investment Research.
*Citigroup assumes most Medicare beneficiaries with coverage through the VA or Department of Defense will continue to get their coverage through them, because the coverage is better than under the standard Medicare drug benefit.
**43M in 2006.

Currently about 11 million Medicare beneficiaries have no drug coverage at all and more than 5 million of those have annual incomes that might make them eligible for a low-income benefit with little cost sharing, depending on whether they meet the maximum assets test.

We assume about a third to one-half (4.5 million is our midpoint estimate) of these uninsured people will sign up for the drug benefit. We base our assumptions on the standard drug benefit package described in the law, which may vary by plan but is supposed to be actuarially equivalent, and statistics on drug usage by the elderly uninsured.

Figure 10: Medicare Standard Drug Benefit*

Type of spending*	Beneficiary pays	Government pays health plans	Health plans pay
Average beneficiary premium. Direct government subsidy or premium per member.**	$32.20 a month; $386.40 a year.**	$60.10 a month; $721.20 a year.	
Deductible	$250		
Co-pay	25% or up to $500 on the next $2000 in spending after deductible		$1,500
Beneficiary additional cost to reach catastrophic threshold (doughnut hole)	$2,850, bringing total out-of-pocket spending with deductible and co-pays to $3,600.		
Catastrophic	5% of cost above $5,100 in spending	80% (reinsurance) cost above $5,100; Government estimates monthly reinsurance payment to health plans of $33.98 per drug benefit enrollee	15% of allowable costs above $5,100

Source: CMS
*Health plans required to provide actuarial equivalent benefit, but patient deductibles and co-payments may vary.
**Premium will vary based on plan bids.

We think survey statistics on prescription drug usage support our view that one third to one half of elderly without drug insurance will sign up for the drug benefit. For example, nearly 35% of elderly uninsured seniors say they take five or more prescriptions a month, according to 2003 survey of the elderly published in an April 19th issue of Health Affairs. Nearly 32% said they take three to four prescriptions.

Further, half of the uninsured elderly said they spent $100 or more a month on drugs. An elderly person spending $100 a month on medicine would see their drug bill reduced by 27% under the standard drug benefit, which includes the average premium cost of $32.20 a month. We think many will pay lower premiums. With $2,400 in costs, an elderly person would spend $1,286 out of pocket, saving 46% with insurance. About half of seniors with incomes at 200 percent of poverty or less rely on 5 different prescriptions.

Figure 11: Comparison of drug costs for uninsured vs. insured Medicare beneficiary

Uninsured beneficiary annual drug spending	Insured beneficiary cost	Insured beneficiary savings
$1,200	$874	27%
$2,250	$1,136	50%
$2,400	$1,286	46%
$3,600	$2,486	31%
$4,800	$3,686	23%
$5,100	$3,986	22%
$6,000	$4,031	33%

Source: Citigroup Investment Research

About 1.9 million elderly get less generous drug coverage through supplemental individual medical insurance plans known as Medigap, according to the CMS. We assume a gradual switch, with the elderly reluctant to immediately drop coverage with which they are familiar.

Kaiser Family Foundation polls show a growing favorable rating of the drug benefit among the elderly. An August poll showed the percentage of elderly who view the drug benefit favorably grew to 32% from 21% in April. The percentage with an unfavorable impression was 32% in August, a statistically insignificant two point improvement over an April survey. The remaining seniors surveyed were either neutral, didn't know or refused to answer. In addition, the Bush Administration said last month that more than 3 million Medicare beneficiaries have applied for low-income assistance to reduce their out-of-pocket costs under the drug benefit. The Social Security Administration said it expects many of the applicants to qualify for extra help and even more elderly to apply.

Thus, we believe the government can meet our expectations signing up enrollees.

Here's why:

- The Bush Administration and the health plans will likely spend hundreds of millions of dollars advertising the availability of a drug benefit. Because Congress created the drug benefit with little Democratic support, the political stakes for the Bush Administration and Republicans are high, and they are making outreach a priority. Plans began marketing Oct. 1.

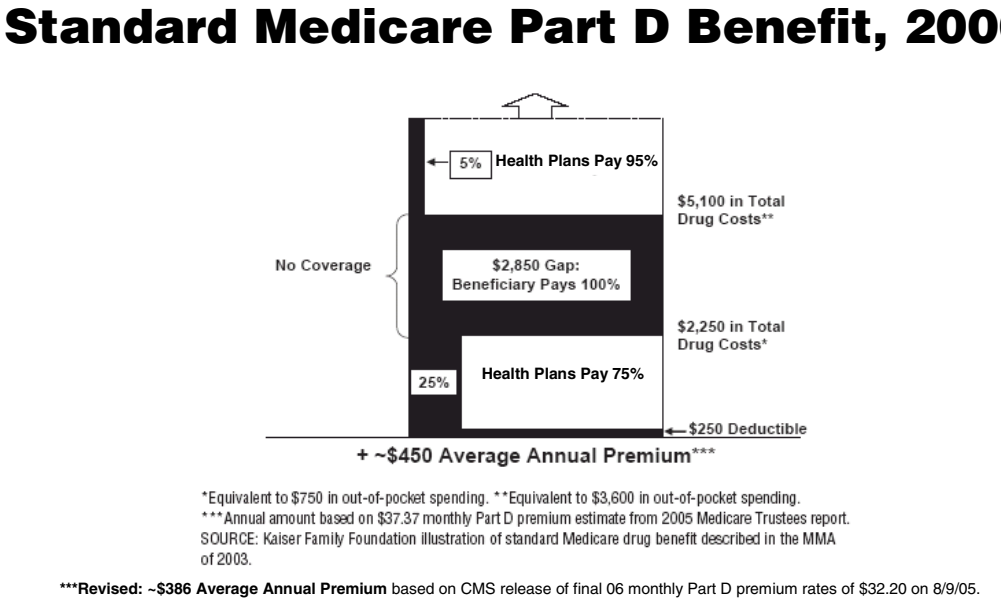
- Unlike with the drug discount card, Democrats are unlikely to launch full-scale attacks designed to discourage the elderly from signing up for the drug benefit. That's because many elderly – especially the poor and sick – benefit from the coverage. The Democrats so far are focusing their efforts on trying to amend the Medicare law to give the government direct control over negotiating drug prices -- as opposed to leaving pricing solely to the health plans and PBMs – and squeezing Medicare reimbursement to the managed-care plans. We don't think they will succeed at either this year.

- Finally, we point out that Medicare signed up more than 90% of the elderly at the start of the Medicare program in 1966 for the voluntary Part B doctor visit portion of the program. The premium was $3 a month -- $18 in today's inflation-adjusted dollars. While $18 is lower than the average $32.20 a month drug benefit premium, we reiterate that

managed-care plans in 44 states will offer zero premium drug benefits, making the drug benefit attractive to many elderly. In addition, prescription drug insurance plans for under $20 a month are available in every state except Alaska, according to the CMS.

The drug benefit is designed in a way that makes it most attractive to the poor and the very sick. The non-poor elderly will need to spend $3,600 out of pocket before qualifying for catastrophic coverage under the standard benefit design. That includes a $2,850 gap in coverage between a Medicare beneficiary's first $2,250 in drug costs and the $5,100 in total drug spending needed to trigger catastrophic coverage. This gap in coverage is widely known as the "doughnut hole".

Figure 12: Standard Medicare Part D Benefit Design



To be sure, some plans will fill the coverage gap or doughnut hole under a benefits package negotiated with the CMS. Plans were allowed to, and did in many cases, negotiate patient cost-sharing that differs from the arrangement in the diagram above. The different benefits designs are allowed as long as they are actuarially equivalent and not discriminatory.

In the California market, the state with the largest elderly population (4.3 million elderly and disabled), 28 of the available prescription drug only plans won't charge a deductible. One of those plans, Humana, PDP Enhanced, will charge a monthly premium of $11.25. That plan's formulary will include 97 of the 100 most commonly prescribed drugs, according to the CMS. Several aspects of plan design still aren't known. For example, the CMS and the plans have not disclosed how much co-payments vary among generics, and preferred and non-preferred brand-name drugs.

Medicare beneficiaries with incomes below 150% of the federal poverty line ($14,355 for a single Medicare beneficiary and $19,245 for a couple) and whose assets fall below certain levels would receive considerable government assistance with out-of-pocket costs, including the elimination of the gap in coverage or doughnut hole. The CMS

estimates that a total of 10.9 million of 14.4 million eligible low-income beneficiaries will sign up for the drug benefit in 2006.

For those who don't qualify for additional coverage from Medicare, Congress and the Bush Administration have created other policies designed to make the drug benefit more generous. For example, the Medicare Modernization Act allows pharmaceutical assistance programs run by the states to provide supplemental coverage to the elderly to enhance the drug benefit package. These additional benefits can include coverage to close the doughnut hole. That coverage would count toward the drug spending required to trigger catastrophic coverage.

Some of these programs help elderly people significantly above the poverty level. For example, the state drug assistance program in Illinois, which has the seventh largest number of elderly among the states, provides help to elderly with annual incomes of up to 300% of the poverty level ($28,710 for a single person and $38,490 for a couple).

As of July 2005, 32 states have pharmaceutical assistance programs. Nine other states have authorized some type of program to provide pharmaceutical assistance or coverage, primarily to low-income elderly or persons with disabilities who do not qualify for Medicaid.

In 2005, laws have been signed in 25 states to adjust or coordinate existing state pharmaceutical programs and policies to better fit with the features of the Medicare drug benefit. Those states are Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, North Dakota, Oklahoma, Vermont, Virginia, and Washington. Additional states are considering bills and resolutions that propose some type of policy change.

State drug assistance programs can be provided as state subsidy programs, discount programs or both. State discount programs include state negotiated price reductions, discount cards and multi-agency purchasing arrangements.

A sampling of current programs in states with large state drug assistance programs or large elderly populations is below.

Figure 13: State Drug Assistance Programs

State	Program	Population	Eligibility
California	Discount Rx Program	850,000	Medicare recipients & disabled; no income limit
Florida	Silver Save Program	46,312	Medicare plus dual-eligibles; 120% FPL*
Florida	Discount Rx Program (enrollment not required)	Not available	Medicare recipients; no income limit; Discounts based on average wholesale price minus 9% + $4.50 dispensing fee, provided by retail pharmacies
Illinois	Circuit Breaker	51,458	Min age 65; single $21,208, married $28,480; disabled over 16
Illinois	Rx SeniorCare	170,482	Min age 65; single $18,620 (200% FPL) married $24,980
Illinois	Rx Buying Club	64,718	Senior citizens & disabled; no income limit
New Jersey	Pharmaceutical Assistance for the Aged and Disabled	187,520	Min age 65; single $19,739 married $24,203; disabled age 21; $5 co-payment
New Jersey	Senior Gold Prescription Discount Program	29,021	Min age 65; single $19,739-$29,739 married $23,204-$34,203; 50% co-payment
New York	EPIC – Elderly Pharmaceutical Insurance Coverage	345,000	Min age 65, single $35,000 married $50,000
Ohio	Golden Buckeye Prescription Drug Savings Program	672,000	Min age 60; no age limit disabled; no income limit
Ohio	Ohio's Best Rx (operational 1/05)	Not available	Min age 60; Also under 60 with family income 250% FPL; single $23,275, married $31,225
Pennsylvania	PACE	191,741	Min age 65; single $14,500, married $17,700
Pennsylvania	PACE Needs Advancement Tier	100,314	Min age 65; single $23,500 married $31,500 ($40/mo deductible)
Texas	Texas Kidney Health Program	17,000	No age limits; individuals $60,000; Must be diagnosed with ESRD, Copay $6 per Rx

Source: National Conference of State Legislatures, 2005

*The federal poverty level (FPL) figures are from February 2005. The guideline for an individual is $9,570. For a married couple or two-person household the figure is $12,830.

Wrap-Around Benefits

Several states are in the process of passing legislation to allow the state drug assistant programs wrap around the Medicare drug benefit. A sampling of states that have created new state drug programs, or modified existing ones, are: Connecticut, Delaware, Hawaii, Illinois, Kentucky, Maine, Massachusetts, Montana, New York and Vermont.

In Illinois, seniors and disabled covered by the state's current program, Circuit Breaker, will receive equivalent coverage once the drug benefit begins. The Illinois Drug Discount program will be extended to cover all residents with incomes under 300% of the federal poverty level, and revises the standards and procedures to ensure that the state can achieve market based manufacturer rebates and pharmacy discounts. Enrollees may receive a state subsidy for federal co-payments over the state's $2 generic and $5 brand co-pay requirement. It is estimated that 235,539 seniors would be eligible for the new Illinois wrap around program. The maximum eligibility for new benefits would be 200% federal poverty level, with existing enrollees grandfathered at up to 250% federal poverty level.

Connecticut authorizes wrap around and coordination of benefits between ConnPACE and the Medicare Modernization Act, including allowing the state to apply on behalf of current state subsidy enrollees. **This ensures that dually eligible Medicare beneficiaries will continue to receive the same level of prescription drug coverage and benefits in 2006 as they do in 2005 under Medicaid.**

In New York, which has the third largest elderly population among the states with 2.5 million, the EPIC program will be coordinated with the Medicare prescription drug program. It provides that Medicare prescription drug plan enrollees will remain eligible for EPIC benefits; the state will pay the portion of the cost for qualified drugs for which no payment or reimbursement is made by the Medicare program or any federally funded prescription drug benefit, less the participant's co-payment. The annual registration fee will be waived for Medicare drug benefit enrollees eligible for the low-income subsidy

Legislation is being considered in other states as well. According to the National Conference of State Legislatures, additional state wrap around programs could be created by the start of the drug benefit on Jan. 1.

Drug utilization boost

The efforts to close the gaps in drug coverage contribute to our view that the drug benefit will likely be modestly positive for brand-name drugmakers over the first couple of years of the benefit.

For seniors with employer retiree coverage, we think the shift is neutral to modestly negative. We expect modest erosion of employer retiree coverage in 2006. To the extent that employers drop retirees, this could be modestly negative. Employers generally offer more generous benefits than retirees would get under the standard Medicare drug benefit. Employers offering retiree drug coverage typically include drug spending as contributing to the overall plan deductible for health spending, don't charge an additional premium for coverage and don't have gap in coverage or doughnut hole before the enrollee qualifies for catastrophic coverage, according to a December 2004

survey by Kaiser and Hewitt Associates, the human resources consulting firm. Eighteen percent of firms surveyed limit patient annual out-of-pocket drug spending (stop-loss), most commonly at $1,500, according to the survey.

In addition, the Medicare drug benefit is excluded from the calculation of the best price available to Medicaid programs. Federal laws require brand-name drugmakers as a condition of doing business with Medicaid to give the program rebates that guarantee it the best price in the marketplace. By excluding Medicare from that calculation, the Medicare prescription drug plans may be able to win larger discounts off drug prices from manufacturers than employers are able to. Industry sources tell Citigroup that Medicare prescription drug health insurers are winning an additional medicine pricing discount of 5% more than they get in their commercial lines of business.

On the other hand, Medicaid, which is run by the states and financed jointly with the federal government, already commands discounts that enable these programs to buy drugs at 51% of the average wholesale price from drugmakers. We believe managed-care health insurers and health plans are seeking to command discounts on behalf of Medicare beneficiaries at 15% to 25% below the average wholesale price, including the additional discount mentioned above.

Next year, about 6 million elderly poor (so-called dual-eligibles) will be automatically switched to Medicare from Medicaid to get their drug benefits if they don't do so voluntarily. We think this is positive for the drug industry, because pricing will likely be better for the manufacturers under Medicare than under Medicaid.

For the approximately 11 million Medicare beneficiaries without drug insurance, we reiterate we expect one third to one half to sign up for a Medicare drug benefit. Since many of these people will qualify for generous low-income coverage, we think their drug utilization will grow at a pace that more than offsets an expected decline in price under Medicare. Generic drugmakers, meantime, will likely lose on the movement of elderly people without medicine insurance into Medicare prescription drug plans. That's because the uninsured will likely be less price sensitive while on drug insurance; so we think elderly currently without drug insurance will be more likely than they are now to use a brand-name drug in place of a substitutable generic.

The Medicare drug benefit will influence the buying power of other payers. It will reduce the drug-price bargaining power of Medicaid which, as a result of the dual-eligibles moving to Medicare, will see its share of U.S. drug spending fall to 9% next year from 18% now, according to government statistics. That's also positive for brand-name drug manufacturers. At the same time, health insurers providing drug benefits to 174 million Americans through employer coverage will gain greater bargaining power with drug manufacturers as these same plans increase the amount of drug benefits they provide to the elderly.

Currently, Medicare managed-care drug benefits are limited. In 2004, 38% of Medicare Advantage enrollees were in managed-care health plans that covered only generic drugs, according to the Kaiser Family Foundation. Nineteen percent were in plans that capped their benefit for brand-name drugs at $1,000 or less, and 29% of enrollees were in plans that did not offer drug coverage, according to Kaiser. Thus, managed-care plans will gain bargaining power over manufacturers from the boost in volume from expanded

coverage under the drug benefit. However, we think the increase in volume will more than compensate drugmakers for the loss on price.

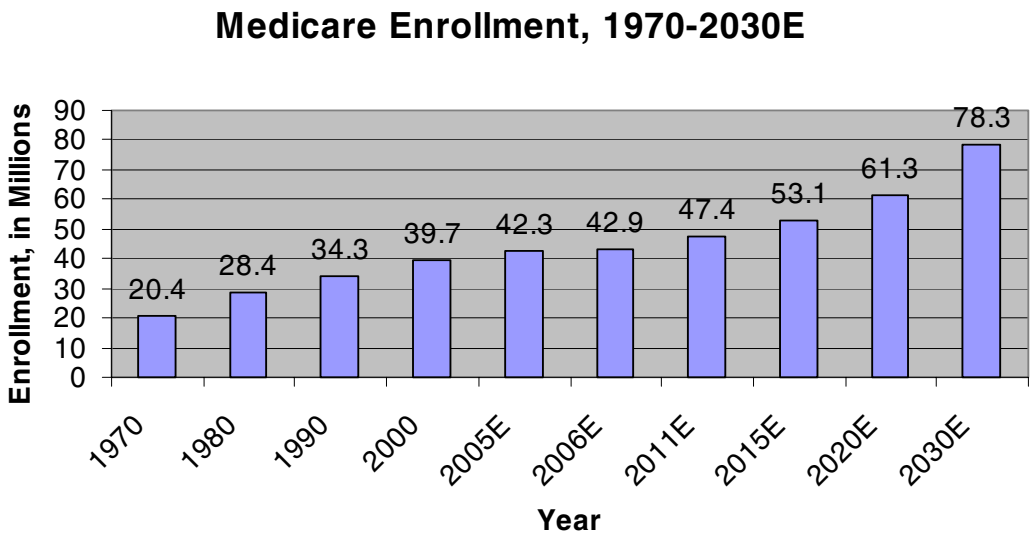
Overall, we think volume gains will offset price cuts under the drug benefit. Toward the end of the decade, however, we think Congress and a new administration in 2009 will face pressure to impose price controls on drugs. At the same time, generic drugmakers will benefit from Congressional pressure to contain Medicare drug costs at the end of the decade.

FUTURE RISKS

Medicare spending pressure

The private sector will need to prove to Congress that privatization serves the best interests of taxpayers. The new Medicare drug benefit law requires Congress and President Bush to seek Medicare savings legislation if Medicare's trustees predict in their annual report that more than 45% of overall Medicare spending will be financed by general taxpayer revenue instead of dedicated funding (payroll tax, premiums) in the next seven years. The threshold needs to be exceeded for two consecutive trustee annual reports, issued each year in March or April, to trigger fast-track legislative action. The most recent report said the threshold won't be exceeded for eight years; thus the report's projections won't until at least 2007 trigger Congressional and presidential action on Medicare savings legislation.

Figure 14: Medicare Enrollment

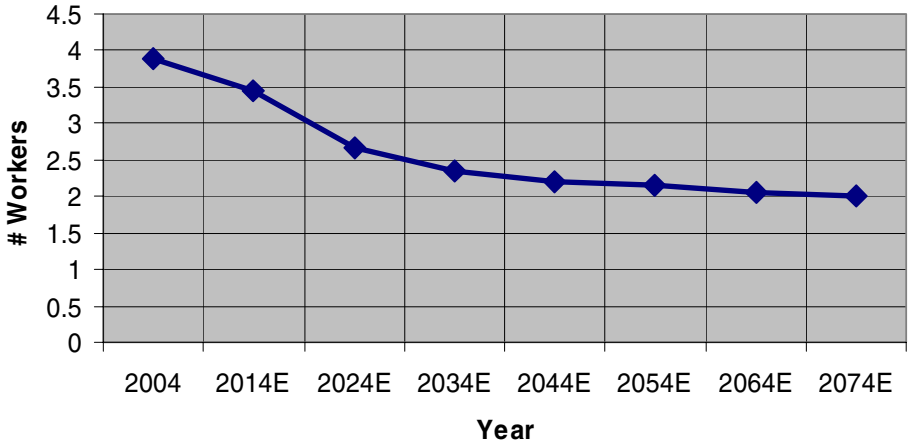


Source: Medicare Trustees Report, 2005

We expect the fast-track legislative process to be triggered in 2007, meaning the President would need to address this issue in his 2008 budget. Given that 2008 is a presidential election year, we think the trigger will help build pressure for containing Medicare spending growth in 2009. With baby boomers starting to turn age 65 in 2011 and thus qualify for Medicare upon retirement, lawmakers and the next president will also face pressure to control program finances. The projected surge in Medicare

enrollment is coupled with the continued anticipated decline in the number of workers per beneficiary financing Medicare through payroll taxes. That poses a potential threat to Medicare payments to hospitals and other health providers, as well as to drugmakers at the end of the decade.

Figure 15: Workers per Medicare Part A (Hospital Insurance) Beneficiary



Source: Medicare Trustees Report, 2005

Timetable for Drug Benefit Implementation

- Oct. 1 – 15: Plan marketing and CMS release of additional details of plan offerings, including formularies and pricing.
- Nov. 15 through May 15: Open enrollment for Medicare beneficiaries to sign up for a prescription drug only plan or for a Medicare managed-care plan.
- January 1, 2006: Coverage begins for those who join by December 31, 2005.

Figure 16: Medigap Insurance

25 Largest Sellers of Medigap Insurance								
				Number of policies in force in 1995				
Company	Total 1994 premiums	Standarized plans offered	States marketed	Standard	Nonstandard	Total	Medical underwriting	Primary method for calculating premiums
UnitedHealth ARRP	2,525,855,458	A through J	Multiple	1,150,214	1,969,743	3,119,957	Yes	Community
Bankers Life and Casulty Company	567,733,657	A through I	Multiple	237,668	202,526	440,194	Yes	Attained age
Empire BCBS	555,536,690	A, B, and H	Single	284,639	119	284,758	No	Community
United American Insurance Company	519,636,376	A, B, C, D, F, and G	Multiple	198,984	180,318	379,302	Yes	Issue age
BCBS of MA	464,472,437	Waived	Single	208,559	7,677	216,236	No	Community
Medical Service Assoc of PA - PA BS	365,244,297	A, B, C and H	Single	513,314	0	513,314	No	Issue age
BCBS of FL	305,529,121	A, B, C, D, and F	Single	94,762	137,565	232,327	No	Issue age
BCBS of IL Health Care Service Corp	254,696,911	A, B, D, E, and F	Single	122,797	167,471	290,268	No	Attained age
BCBS of VA	203,832,750	A, B, C, F, I, and J	Single	32,217	93,711	125,928	Yes	Issue age
BCBS of NC	184,107,328	All except G	Single	55,308	85,267	140,575	Yes	Issue age
Mutual of Omaha Insurance Company	183,430,118	A, C, F, and I	Multiple	100,000	150,000	250,000	Yes	Attained age
Pioneer Life Insurance Company of IL	180,965,855	A, B, C, D, E, F, G, and I	Multiple	84,146	71,821	155,967	Yes	Attained age
BCBS of IN Associated Insurance Co.	180,200,050	A, B, C, D, F, G, and H	Single	43,000	107,000	150,000	Yes	Attained age
BCBS of NJ	179,058,000	A, C, F, and I	Single	33,167	158,485	191,652	Yes	Community
Physicians Mutual Insurance Company	176,543,759	A through J	Multiple	105,372	58,690	164,062	Yes	Issue age
BCBS of AL	165,647,335	A and B	Single	178,000	0	178,000	No	Issue age
BCBS of IA-IASD Health Services Corp.	157,659,892	A, C, E, F, and J	Single	60,443	40,235	100,678	Yes	Attained age
BCBS of MI	155,410,958	A, C, and H	Single	39,201	148,158	187,359	No	Community
BCBS of CT	154,283,955	A, B, C, D, F, and H	Single	20,193	128,979	149,172	Yes	Community
Standard Life and Accident Insurance Co.	151,782,693	A, B, C, and F	Multiple	45,000	60,000	105,000	Yes	Issue age
BCBS of TN	142,747,238	A through J	Single	33,250	124,150	157,400	Yes	Attained age
BCBS of KS	134,673,000	A, C, and F	Single	105,570	33,486	139,056	Yes	Attained age
Blue Cross of Western PA	130,848,816	A, B, C, and H	Single	187,569	0	187,569	No	Issue age
State Farm Mutual Insurance Company	126,533,729	A and C	Single	441	84,768	85,209	No	Attained age
American Family Life Assurance Company of Columbus, GA	124,216,026	A, B, C, F, and G	Multiple	55,075	46,500	101,575	Yes	Issue age
Subtotal Blue Cross Blue Shield	3,733,948,778			2,011,989	1,232,303	3,244,292		
Total All	**8,290,646,449**			**3,988,889**	**4,056,669**	**8,045,558**		

Source: US General Accounting Office report to Congressional Committees. "Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting", September 1996.

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