Healthcare Services

United States

Medicare drug benefit

The Goldman Sachs Group, Inc.

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Pharmacy Benefit Managers
Coverage view: Neutral

Managed Care
Coverage view: Neutral

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Part D coming into focus. Based on new disclosures from CMS, we have updated our analysis for the impact of MMA Part D on the PBM and managed care sectors. We expect Caremark and Humana to benefit most in 2006, while non-traditional PBM competitors (managed care and drug retailers) are gaining share.

Market forces at work; MMA competition drives down Part D premiums

Careful planning by CMS (and a large market opportunity) has attracted a large number of plan participants, with over 1,400 drug plans being offered across 34 PDP regions, forcing down average monthly premiums more than 10%. We estimate that the high number of low-premium plans (less than $5) will remove $990 million in vendor economics in 2006.

We believe some PDP plans are positioned as loss leaders

We interpret the wide disparity in drug plan pricing as a combination of strategy differences among plans and variations in actuarial assumptions. However, we believe the low-priced drug plans offered by Humana are a marketing strategy to capture positive risk selection members (attracting low-utilizing seniors) while creating an efficient feeder system for more attractive MA enrollment in 2007 and beyond.

Traditional PBM participation limited; non-traditional plans gain share

Combining direct PDP plans (Caremark and Medco Health Solutions) and pre-existing managed care reseller relationships (via MA and MA-PDP plans), we forecast that only Caremark will benefit from any MMA enrollment (and earnings) windfall. Walgreen and the captive pharmacy operations of managed care firms exceeded our enrollment expectations, with more than 50% of forecasted total MMA enrollment, an outcome with potential implications for the commercial market.

Managed care companies appear best positioned to benefit

For managed care, we look to the early 2006 rate of conversion of seniors to MA as a key determinant in our longer-term sector view. An initially high conversion rate would imply that multiyear growth is more likely with lower cyclical risk to the industry. In our view, UNH and WLP are best positioned on PDP and HUM is best positioned on MA.

For Reg AC certification, see page 50. For other important disclosures, see page 53, go to http://www.gs.com/research/hedge.html, or contact your investment representative.

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Expected news flow/events

Date	Event	Notes
October 21, 2005	Retiree drug subsidy applications approved or rejected	Approximately 10.9 million Medicare beneficiaries have employer sponsored coverage. The CBO estimates 8.2 million will continue to receive coverage through their employer.
November 15, 2005	Open enrollment begins for 2006 Part D	Early indications of enrollment progress will be closely monitored.
January 1, 2006	Part D benefits begin for enrolled beneficiaries and dual eligibles	5.7 million dual eligibles at a minimum will be enrolled (excluding MA enrollees).
March 1, 2006	CMS identifies number of beneficiaries not enrolled in Part D	Will provide an important metric of Part D momentum.
May 15, 2006	Last day to enroll in Part D for 2006	The CBO projects 29 million will be enrolled by the end of 2006, with most enrolling before the initial enrollment period ends.
May 16, 2006	Late enrollment penalty begins	Penalty is minimal for postponing enrollment for a few months, which could lead some to wait and see.
November 15, 2006	Open enrollment begins for 2007 Part D	The number of beneficiaries that switch plans in the 2nd enrollment period will be an important indicator of plan "stickiness." Also expect to see news on complaints or reasons why beneficiaries switched plans.
December 31, 2006	Last day to enroll in Part D for 2007	Look for "who wins and who loses" in terms of number of enrollees.

Source: Centers for Medicare and Medicaid Services.

Summary: Part D coming into focus

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) Part D will provide Medicare-eligible seniors out-patient prescription drug coverage for the first time. Although there has been a significant amount of information on the size of the Medicare population and standard plan structures, until recently investors have had limited information as to the number of participating plans and how pricing and benefits would differ among regions. In this report we provide an overview of the Medicare opportunity, update our analysis first presented in our June 8 report titled *Demystifying Part D* based on published premium data, summarize plan information recently released by CMS (Centers for Medicare and Medicaid Services), and analyze the potential market opportunity for managed care organizations (MCOs) and the three independent pharmacy benefit managers (PBMs) – Caremark, Medco Health, and Express Scripts.

Medicare Part D represents important market opportunity

There are currently 43 million seniors and disabled Americans that qualify for Medicare benefits. The implementation of an out-patient prescription drug benefit under part D will provide drug coverage for approximately 15.6 million seniors who previously had no drug coverage. Moreover, plan designs could increase same-patient utilization as price-sensitive seniors respond to greater purchasing power. We estimate that MMA will generate 45 million new prescriptions (Rx) in 2006 and $9.4 billion in new prescription spending.

Competition has driven average monthly premiums down more than 10%

CMS has approved more than 1,400 plans that have a monthly premium of $32.20 on average compared with CMS's original estimates of $37.00 (down 13%). This will reduce the annual premium to $386 from $444 and reduce the participants' breakeven cost to $765 (from $810), making the benefit slightly more attractive to seniors. Based on the number of plans and the wide range of premiums, it appears that price is a major competitive factor among plan sponsors.

Dual-eligible participants to be spread broadly among auto-enroll eligible plans

On average there are 8 plans approved for auto enrollment of dual eligibles, with some regions having as many as 14 approved plans. Our analysis suggests that the economic benefit of participation may not be material on a regional basis given the large number of plans receiving dual eligibles. However, dual eligibles could provide important margin leverage to open enrollees by allowing plan sponsors to amortize costs.

Many plans, many options – we expect a tepid rate of senior enrollment in 2006

Given the large number of plans being offered across the nation with varying premiums, deductibles, formulary, coverage in the "doughnut hole" (no coverage between $2,250 and $5,100 in aggregate spending), and mail-order options, it appears that seniors are going to face a complex and confusing decision-making process. We believe price, name recognition of the plan sponsor, and the richness of benefits being offered will be important factors in the decision-making process.

Only Caremark poised to benefit from Part D economics

In position to secure meaningful market share in both the dual-eligible and open-enrollment populations, Caremark (OP/N) has meaningfully outpaced its PBM peers Express Scripts (U/N) and Medco Health (IL/N). We estimate that Part D could benefit Caremark's earnings $0.18-$0.26 per share in 2006.

Incremental impact on US pharmaceutical market spending estimated at $16 bn

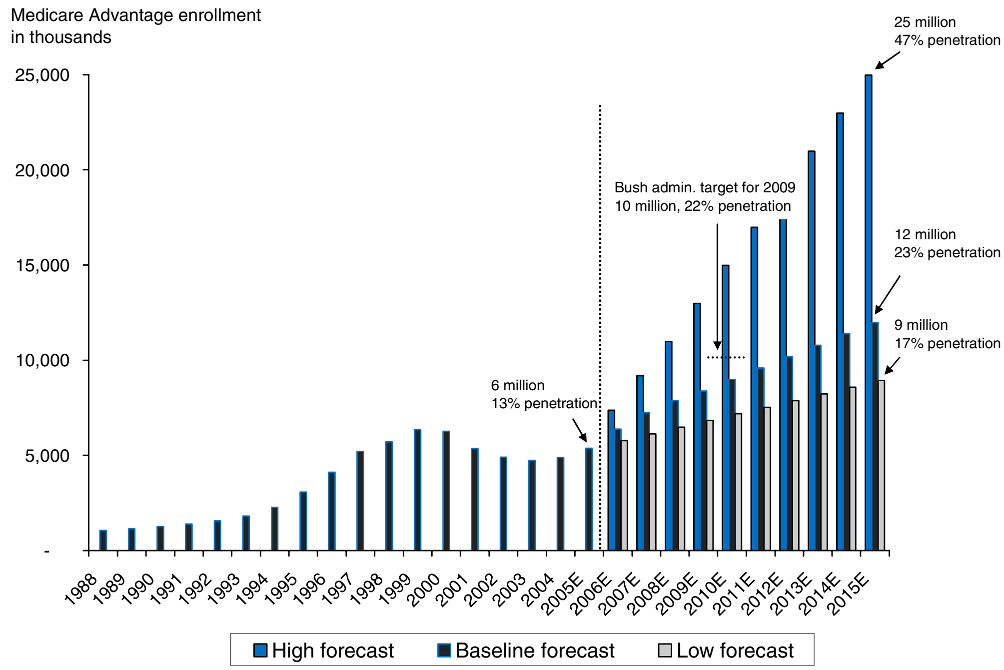
Based on our analysis and forecast of the plan type and timing of enrollment, we estimate that 42 million incremental prescriptions will be filled in 2006 (off a base of roughly 4 billion) and $9 billion in incremental prescription spending (off a $250-billion base). We estimate the impact on drug wholesaler earnings in the range of $0.04-$0.13 in 2006.

For managed care, the conversion rate to MA will be a key factor in the outlook

With 36 million beneficiaries in traditional Medicare and with Medicare Advantage (MA) reimbursement at over $10,000 per senior per year (about 10X the per-member revenues of PDP), we view MA as a more significant and longer-term growth opportunity for managed care versus stand-alone PDP.

Accordingly, we look to the early 2006 rate of conversion of seniors to MA as a key determinant in our longer-term sector view. An initially high conversion rate would imply that multiyear growth is more likely (Exhibit 1) with lower cyclical risk to the industry.

Exhibit 1: MA conversion rate is a key factor in long-term outlook for managed care
Medicare Advantage enrollment: high, baseline, and low GS forecasts, 1988-2015E



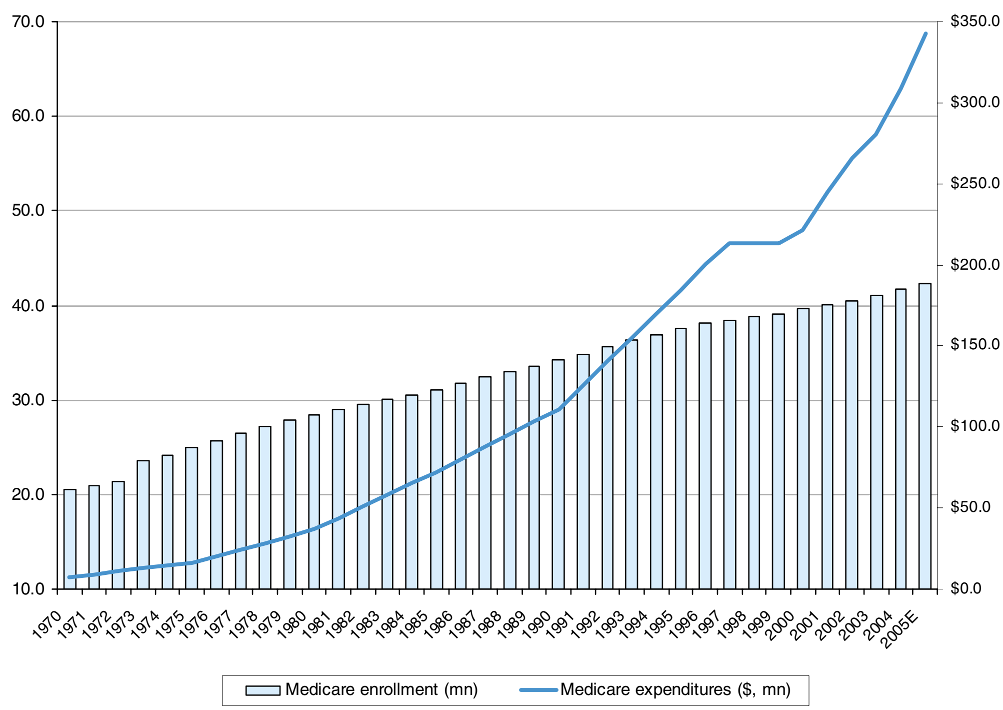
Source: CMS.

The Medicare expansion opportunity

As the largest expansion of the Medicare program since its inception in 1965, the implementation of Medicare Part D is expected to significantly increase drug utilization as almost 16 million seniors, who previously had no drug coverage, are provided an outpatient drug benefit. Based on the information released by CMS over the past two weeks, there will likely be a significant competition by managed care companies and PBMs to capture senior enrollment both for dual eligibles (under auto-enrollment programs) and the general population.

There are currently 43 million seniors and disabled Americans that qualify for Medicare benefits (Exhibit 2). This number is expected to reach 77 million by 2030, growing at a 3% compounded rate. The large size of the Medicare population has significant implications for healthcare as senior healthcare expenditures in aggregate are three to four times higher than for the under-65 population. The addition of a prescription drug benefit through the Medicare Modernization Act of 2003 (MMA Part D) provides a market opportunity for MCOs and PBMs that participate in this program. As per CMS, MMA may cost the US government $1.2 trillion over the next decade.

Exhibit 2: Medicare enrollment trends: program currently covers 43 mn seniors and disabled

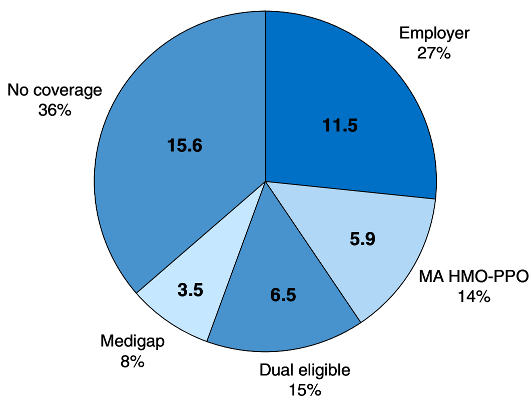


Source: CMS.

Introduction of Part D will increase drug benefit-eligible seniors

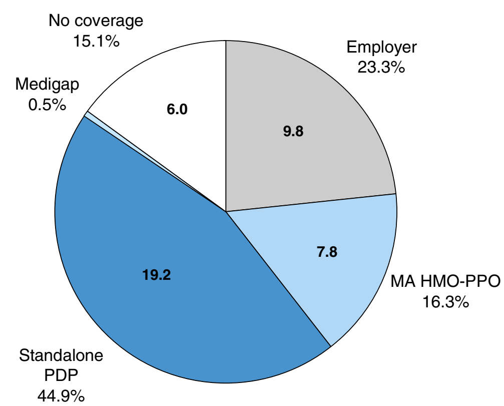
Currently 36% of the Medicare-eligible population does not have drug coverage (see Exhibit 3). Under MMA Part D all seniors will be eligible for coverage. Exhibit 4 provides our estimated breakout of beneficiaries in 2006 under MMA Part D. We expect MA enrollment to increase from 5.9 million to 7.8 million as managed care companies accelerate their marketing and use the drug benefit to draw seniors into MA programs. We expect employer coverage to drop from 11.5 million to 9.8 million as employers decide to shift seniors out of employer-based healthcare plans into Medicare in lieu of receiving the 28% tax subsidy offered to employers under MMA. Medigap will no longer accept new members and dual eligibles will be auto enrolled in a PDP program. We estimate that 8.6 million seniors who do not currently have drug coverage will enroll into a stand-alone PDP and stand-alone PDPs will cover approximately 19.2 million beneficiaries (Exhibit 4).

Exhibit 3: Drug coverage for Medicare beneficiaries, 2005E
millions



Source: CMS, EBRI and Goldman Sachs Research estimates.

Exhibit 4: Drug coverage for Medicare beneficiaries, 2006E
millions



Source: CMS, EBRI and Goldman Sachs Research estimates.

We assume modest adoption outside auto-enrolled population

Exhibit 5 provides a more detailed look at the expected breakout of Medicare beneficiaries in 2005 and where we expect them to go under MMA Part D. We have made assumptions by benefit status for enrollment in PDP, MA-PDP, and non-enrollment. Given the complexity of the program and need for seniors to “opt-in,” we expect roughly 38% of seniors currently without coverage not to enroll in 2006.

Exhibit 5: Distribution of drug coverage
43 million beneficiaries, 2005E-2006E

Distribution of Medicare recipients - 2005 (millions)		For 2006 we expect (mn of lives):			
Category	# of lives	Join PDP	Join MA plan	Continue current cvg	No coverage
Employer-provided retiree coverage 85% continue employer cov'g, 14% join PDP, 1% join MA plan	11.5	1.6	0.1	9.8	-
Medicare Advantage (HMO, PPO) 97% continue MA plan, 3% join PDP	5.9	0.2	5.7	-	-
Medicare-Medicaid "dual eligibles" 88% join or auto-assign to PDP plan, 12% join MA plan	6.5	5.7	0.8	-	-
Medigap drug plans 90% join PDP, 6% continue Medigap, 4% join MA plan	3.5	3.2	0.1	0.2	-
No coverage, eligible for subsidy 60% join PDP, 8% join MA plan, 33% do nothing (no coverage)	4.6	2.8	0.4	-	1.5
No coverage, not eligible for subsidy 53% join PDP, 6% join MA plan, 41% do nothing (no coverage)	11.0	5.8	0.7	-	4.5
TOTAL	**43.0**	**19.2** 45%	**7.8** 18%	**10.0** 23%	**6.0** 14%

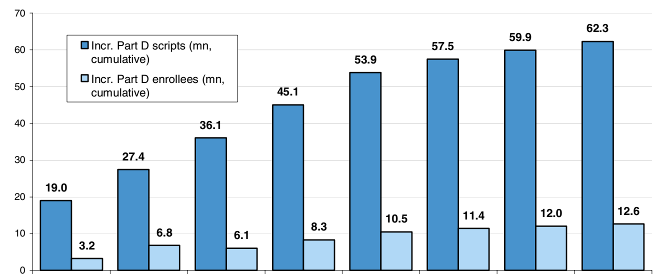
Source: CMS, EBRI and Goldman Sachs Research estimates.

Consolidated enrollment and script volume assumptions

Building on Exhibit 5, we forecast enrollment by quarter (though 2007) and link assumptions regarding changes in utilization by type of senior benefit. We expect 25.7 million total enrollees (MA and MA-PDP) by the end of 2006 (see Exhibit 6). However, the ramp of enrollment (note first-time seniors have until May 15 to enroll with a very modest penalty for extending the enrollment timeline) implies a more modest impact on the pharmaceutical supply chain. We forecast only $9.4 billion in incremental Rx spending in 2006, a 4% increase over the current market growth rate.

Exhibit 6: Incremental Part D enrollees and scripts (PDP + MA) by quarter

By end of 2007, 12.6 mn incremental beneficiaries will account for 60.3 mn new scripts



Cumulative PDP and MA enrollees by quarter (mn)	Mar 06E	Jun 06E	Sep 06E	Dec 06E	Mar 07E	Jun 07E	Sep 07E	Dec 07E
Employer-provided retiree coverage enrollees (11.5mn total, 14% join PDP, 1% join MA)	**1.7**	1.7	1.7	1.7	1.9	2.0	2.1	2.1
Incremental enrollees	**-**	-	-	-	-	-	-	-
Incremental scripts (0 per capita)	-	-	-	-	-	-	-	-
Medicare Advantage enrollees (HMO, PPO) (5.9mn total, 3% join PDP, 97% join MA)	**5.9**	5.9	5.9	5.9	5.9	5.9	5.9	5.9
Incremental enrollees	**-**	-	-	-	-	-	-	-
Incremental scripts (2 per capita)	**11.8**	11.8	11.8	11.8	11.8	11.8	11.8	11.8
Medicare-Medicaid "dual eligibles" enrollees (6.5mn total, 88% join PDP, 12% join MA)	**6.5**	6.5	6.5	6.5	6.5	6.5	6.5	6.5
Incremental enrollees	**-**	-	-	-	-	-	-	-
Incremental scripts (0 per capita)	-	-	-	-	-	-	-	-
Medigap drug plans enrollees (3.5mn total, 90% join PDP, 4% join MA)	**1.6**	**3.3**	3.3	3.3	3.3	3.3	3.3	3.3
Incremental enrollees	**1.6**	**3.3**	-	-	-	-	-	-
Incremental scripts (0.5 per capita)	**0.8**	**1.6**	-	-	-	-	-	-
No coverage, eligible for subsidy enrollees (4.6mn total, 60% join PDP, 8% join MA, 33% not covered)	**0.9**	**1.9**	**2.5**	**3.1**	**3.4**	**3.6**	**3.7**	**3.9**
Incremental enrollees	**0.9**	**1.9**	**2.5**	**3.1**	**3.4**	**3.6**	**3.7**	**3.9**
Incremental scripts (4 per capita)	**3.8**	**7.5**	**10.0**	**12.5**	**13.4**	**14.3**	**14.9**	**15.5**
No coverage, not eligible for subsidy enrollees (11.0mn total, 53% join PDP, 6% join MA, 41% not covered)	**0.6**	**1.6**	**3.6**	**5.2**	**7.2**	**7.8**	**8.3**	**8.7**
Incremental enrollees	**0.6**	**1.6**	**3.6**	**5.2**	**7.2**	**7.8**	**8.3**	**8.7**
Incremental scripts (4 per capita)	**2.6**	**6.5**	**14.3**	**20.8**	**28.7**	**31.4**	**33.2**	**35.0**
TOTAL - PDP & MA enrollees	17.4	20.9	23.5	25.7	28.1	29.1	29.8	30.4
TOTAL - Incremental PDP & MA enrollees	3.2	6.8	6.1	8.3	10.5	11.4	12.0	12.6
TOTAL - Incremental scripts	19.0	27.4	36.1	45.1	53.9	57.5	59.9	62.3

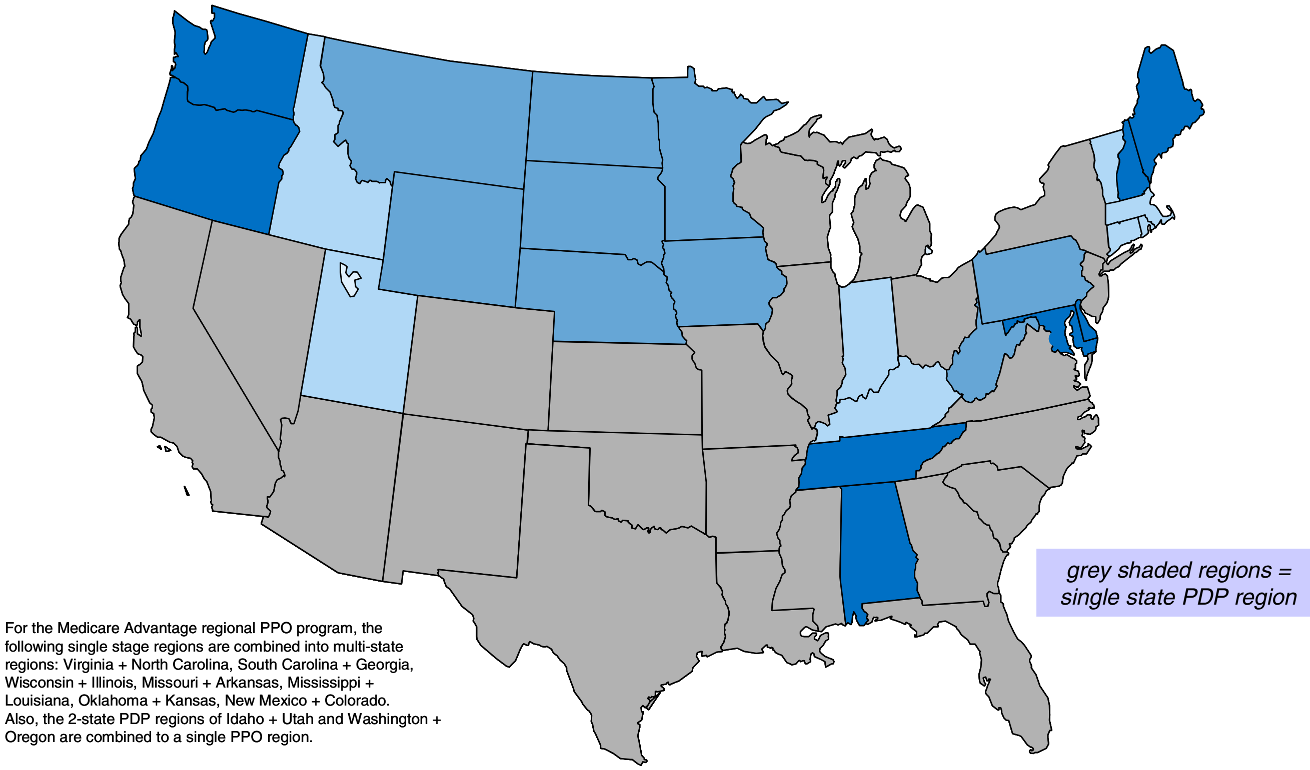
- New incremental enrollment

Source: CMS, Goldman Sachs Research estimates.

Regional structure may increase launch costs in 2006

CMS has broken the United States into 34 PDP and 26 MA regions (Exhibit 7). Some states are stand-alone regions, while less populated states have been combined to form regions. There is significant number of regions in order to foster competition within regions of smaller players that may not have had the scale to compete on a more national basis. Our earnings sensitivity analysis for PBMs assumes one-time launch costs of $50,000-$300,000 per region.

Exhibit 7: Medicare PDP regions
34 PDP regions and 26 MA PPO regions



Source: CMS.

Dual-eligible population described

Medicaid is a state-administered, income-based healthcare plan offered to all age groups. Historically, low-income seniors (over 65) who were enrolled in the Medicare program for medical benefits could also enroll in state Medicaid programs to receive prescription drugs if they met income requirements. To streamline the administration of benefits to these estimated 6.5 million patients (and to provide some fiscal relief to states) Congress moved to shift the pharmacy benefit of dual-eligible seniors from Medicaid to Medicare under MMA. Exhibit 8 provides details on the dual-eligible populations nationally.

Exhibit 8: Medicaid and dual eligibles

On average, dual eligibles comprise about 13.8% of the total Medicaid population

	2004							2005 (a)				
State	Medicaid enrollees (mn)	Dual eligibles (b) (mn)	Dual eligibles % of total	Medicaid enrollees % growth	Dual eligibles % growth	Rx spend ($. mn)	Rx spend % of total	Medicaid enrollees (mn)	Dual eligibles (b) (mn)	Dual eligibles % of total	Medicaid enrollees % growth	Dual eligibles % growth
AL	842.6	176.9	21.0%	4.7%	4.7%	467.2	22.3%	882.2	185.3	21.0%	4.7%	4.7%
AK	113.6	9.1	8.0%	1.0%	1.0%	86.1	16.3%	118.2	9.5	8.0%	4.0%	4.0%
AZ	940.7	75.3	8.0%	1.7%	1.7%	5.4	0.1%	1,043.3	83.5	8.0%	10.9%	10.9%
AR	696.4	132.3	19.0%	6.7%	6.7%	298.2	20.8%	734.0	139.5	19.0%	5.4%	5.4%
CA	10,063.6	1,006.4	10.0%	2.9%	2.9%	3,205.6	16.7%	10,174.3	1,017.4	10.0%	1.1%	1.1%
CO	538.7	80.8	15.0%	10.7%	10.7%	203.9	12.9%	601.8	90.3	15.0%	11.7%	11.7%
CT	563.3	95.8	17.0%	7.6%	7.6%	259.9	20.4%	582.5	99.0	17.0%	3.4%	3.4%
DE	170.6	17.1	10.0%	6.6%	6.6%	97.2	23.5%	179.6	18.0	10.0%	5.3%	5.3%
FL	2,933.7	440.1	15.0%	0.7%	0.7%	1,801.9	23.2%	3,027.6	454.1	15.0%	3.2%	3.2%
GA	1,625.3	195.0	12.0%	6.0%	6.0%	956.9	16.2%	1,722.9	206.7	12.0%	6.0%	6.0%
HI	219.5	24.2	11.0%	5.0%	5.0%	89.4	15.7%	234.9	25.8	11.0%	7.0%	7.0%
ID	230.8	13.8	6.0%	6.5%	6.5%	123.3	26.3%	243.7	14.6	6.0%	5.6%	5.6%
IL	na	na	na	na	na	1,282.2	21.5%	na	na	na	na	na
IN	1,053.0	136.9	13.0%	5.3%	5.3%	526.6	22.7%	1,109.9	144.3	13.0%	5.4%	5.4%
IA	407.9	73.4	18.0%	6.4%	6.4%	287.2	26.6%	432.3	77.8	18.0%	6.0%	6.0%
KS	343.4	51.5	15.0%	7.3%	7.3%	208.8	29.2%	359.2	53.9	15.0%	4.6%	4.6%
KY	890.9	160.4	18.0%	2.8%	2.8%	633.4	22.9%	939.0	169.0	18.0%	5.4%	5.4%
LA	1,137.5	159.2	14.0%	7.6%	7.6%	724.1	21.6%	1,187.5	166.3	14.0%	4.4%	4.4%
ME	345.7	89.9	26.0%	9.6%	9.6%	147.1	26.1%	360.5	93.7	26.0%	4.3%	4.3%
MD	893.0	98.2	11.0%	4.5%	4.5%	399.6	14.6%	915.3	100.7	11.0%	2.5%	2.5%
MA	1,271.5	216.2	17.0%	-3.5%	-3.5%	710.2	13.9%	1,290.6	219.4	17.0%	1.5%	1.5%
MI	1,826.5	237.4	13.0%	6.0%	6.0%	628.0	10.7%	1,912.3	248.6	13.0%	4.7%	4.7%
MN	807.2	129.2	16.0%	5.0%	5.0%	302.4	12.9%	844.3	135.1	16.0%	4.6%	4.6%
MS	na	na	na	na	na	542.7	25.4%	na	na	na	na	na
MO	1,282.2	166.7	13.0%	5.5%	5.5%	899.1	21.9%	1,309.2	170.2	13.0%	2.1%	2.1%
MT	118.3	16.6	14.0%	3.5%	3.5%	78.6	25.2%	120.1	16.8	14.0%	1.5%	1.5%
NE	285.9	37.2	13.0%	-2.2%	-2.2%	184.7	27.7%	297.6	38.7	13.0%	4.1%	4.1%
NV	196.7	31.5	16.0%	4.9%	4.9%	99.0	14.8%	207.3	33.2	16.0%	5.4%	5.4%
NH	132.3	21.2	16.0%	5.8%	5.8%	95.3	17.3%	138.6	22.2	16.0%	4.8%	4.8%
NJ	1,078.7	183.4	17.0%	3.6%	3.6%	819.2	19.5%	1,100.2	187.0	17.0%	2.0%	2.0%
NM	545.3	43.6	8.0%	6.4%	6.4%	92.9	6.2%	553.5	44.3	8.0%	1.5%	1.5%
NY	4,268.2	640.2	15.0%	2.6%	2.6%	3,820.1	17.6%	4,537.1	680.6	15.0%	6.3%	6.3%
NC	1,632.9	293.9	18.0%	4.6%	4.6%	1,250.3	24.7%	1,667.2	300.1	18.0%	2.1%	2.1%
ND	76.3	16.0	21.0%	0.2%	0.2%	45.7	28.2%	75.7	15.9	21.0%	-0.9%	-0.9%
OH	2,123.6	233.6	11.0%	5.7%	5.7%	1,372.1	22.9%	2,221.3	244.3	11.0%	4.6%	4.6%
OK	744.3	104.2	14.0%	4.2%	4.2%	342.1	24.7%	767.4	107.4	14.0%	3.1%	3.1%
OR	636.3	70.0	11.0%	-11.4%	-11.4%	191.3	13.0%	598.1	65.8	11.0%	-6.0%	-6.0%
PA	1,979.1	336.4	17.0%	5.8%	5.8%	755.9	10.5%	2,139.4	363.7	17.0%	8.1%	8.1%
RI	na	na	na	na	na	128.0	15.8%	na	na	na	na	na
SC	1,062.3	127.5	12.0%	2.8%	2.8%	509.4	19.7%	1,062.3	127.5	12.0%	0.0%	0.0%
SD	124.8	18.7	15.0%	4.0%	4.0%	64.4	21.7%	129.0	19.4	15.0%	3.4%	3.4%
TN	1,790.3	286.5	16.0%	-1.9%	-1.9%	1,703.3	32.2%	1,865.5	298.5	16.0%	4.2%	4.2%
TX	3,395.7	543.3	16.0%	7.8%	7.8%	1,694.7	18.1%	3,650.4	584.1	16.0%	7.5%	7.5%
UT	261.3	20.9	8.0%	10.0%	10.0%	146.3	17.0%	271.7	21.7	8.0%	4.0%	4.0%
VT	184.8	31.4	17.0%	4.7%	4.7%	124.1	33.1%	184.8	31.4	17.0%	0.0%	0.0%
VA	878.5	166.9	19.0%	9.1%	9.1%	444.2	19.6%	940.9	178.8	19.0%	7.1%	7.1%
WA	1,181.2	118.1	10.0%	0.1%	0.1%	500.3	15.9%	1,198.9	119.9	10.0%	1.5%	1.5%
WV	396.0	55.4	14.0%	-1.0%	-1.0%	268.9	26.3%	403.9	56.5	14.0%	2.0%	2.0%
WI	850.9	136.1	16.0%	7.2%	7.2%	522.9	24.2%	903.7	144.6	16.0%	6.2%	6.2%
WY	76.2	9.9	13.0%	10.1%	10.1%	40.9	24.2%	84.0	10.9	13.0%	10.2%	10.2%
TOTAL	**53,217.3**	**7,328.2**	**13.8%**	**-2.2%**	**-1.6%**	**30,181.0**	**18.4%**	**55,323.4**	**7,635.8**	**13.8%**	**4.0%**	**4.2%**

(a) Full-year spend data not available for 2005

(b) Includes "partial" dual eligibles who don't receive prescription drug coverage under Part D.

Source: CMS.

Updated MMA Part D framework

Our June 8, 2005 report, *Demystifying Part D*, provided a comprehensive analysis of MMA Part D preliminary plan design expectations based on information available at that time. Now that final plans have been approved, we have updated information, including a new average monthly premium of $32.20 versus CMS's original estimate of $37.00.

In Exhibit 9 we have reduced the 2006 annual premium to $386 from $448 based on an average plan premium of $32.20. The average premium across all plans is 13% lower than CMS's original estimate. This results in total cost for the enrollee reaching the out-of-pocket threshold of $3,986 in 2006, 2% lower than our previous estimate of $4,048.

Exhibit 9: Congressional Budget Office (CBO) estimates of standard benefit
Deductible, premium, and out-of-pocket threshold will rise significantly, coverage gap widens to over $5,000

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Annual deductible	$250	$270	$290	$310	$331	$352	$373	$404	$437
Out-of-pocket threshold	$3,600	$3,892	$4,176	$4,468	$4,767	$5,068	$5,367	$5,817	$6,295
	$32	$41	$44	$46	$49	$52	$55	$60	$64
Annual premium	$386	$495	$525	$556	$587	$619	$665	$717	$771
Total cost for enrollee reaching OOP threshold	$3,986	$4,387	$4,701	$5,024	$5,354	$5,687	$6,032	$6,534	$7,066
Y/Y % increase		10.0%	7.2%	6.9%	6.6%	6.2%	6.1%	8.3%	8.1%
Coverage Gap	$2,850	$3,126	$3,448	$3,676	$3,995	$4,315	$4,670	$5,066	$5,066

Old CBO estimates									
Annual premium	**$37**	**$41**	**$44**	**$46**	**$49**	**$52**	**$55**	**$60**	**$64**
		10.3%	**6.1%**	**5.9%**	**5.7%**	**5.4%**	**7.5%**	**7.7%**	**7.6%**

Source: CMS, CBO, Medicare Trustees Report 2005, Goldman Sachs Research estimates.

The lower Part D premium, partially offset by a slightly higher-than-expected Part B premium and deductible, will reduce the total amount paid by seniors for Part A, B, and D in 2006 $52 to $2,778 (see Exhibit 10).

Exhibit 10: Combined Part A, B, and D premiums and deductibles will place a larger burden on many seniors

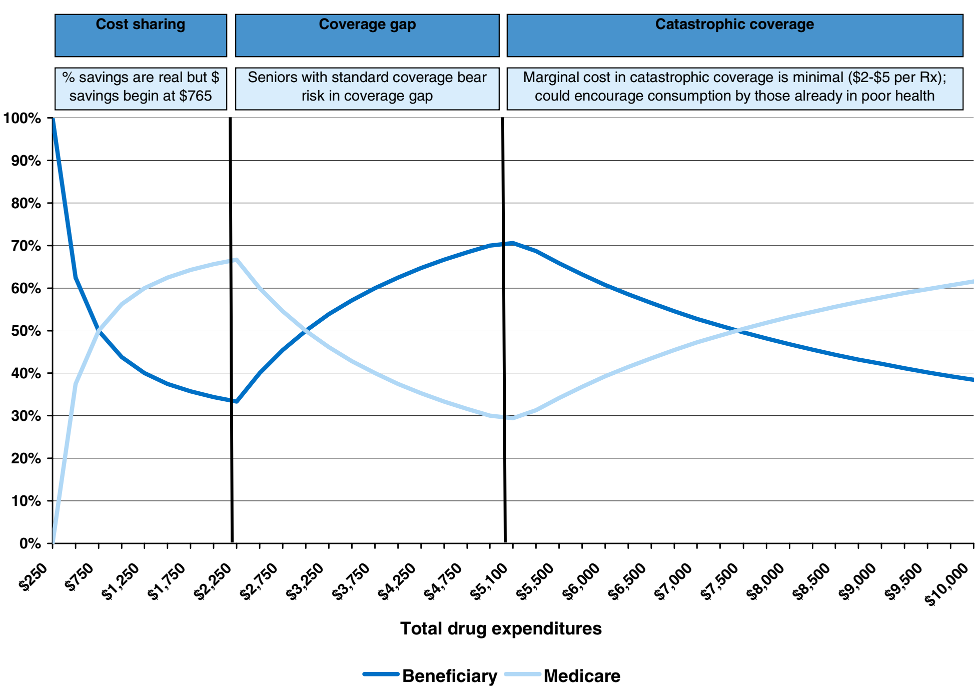
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Premiums									
Part A*	$0	$0	$0	$0	$0	$0	$0	$0	$0
Part B (monthly)	$78	$89	$89	$89	$89	$92	$95	$100	$107
Part B	$938	$1,062	$1,062	$1,062	$1,072	$1,104	$1,138	$1,196	$1,285
Part D	NA	$386	$495	$525	$556	$587	$619	$665	$717
Combined	NA	$1,448	$1,557	$1,587	$1,627	$1,691	$1,757	$1,862	$2,002
Deductibles									
Part A	$912	$956	$1,004	$1,056	$1,108	$1,164	$1,220	$1,276	$1,336
Part B	$110	$124	$124	$124	$125	$129	$133	$140	$150
Part D	NA	$250	$270	$290	$310	$331	$352	$373	$404
Combined	NA	$1,330	$1,398	$1,470	$1,543	$1,624	$1,705	$1,789	$1,890
Total Deductible and Premium	NA	$2,778	$2,955	$3,057	$3,170	$3,315	$3,462	$3,651	$3,892
Growth			6.3%	3.5%	3.7%	4.6%	4.4%	5.5%	6.6%

*Medicare beneficiaries do not pay a Part A premium if they or their spouse has 40 or more quarters of Medicare covered employment.

Source: Medicare Trustees Report, CMS and Goldman Sachs Research estimates.

The percentage and level of savings will vary significantly with the amount of drug expenditures. In percentage terms, seniors with spending near the start of the coverage gap and those with the highest expenditures will have the greatest savings.

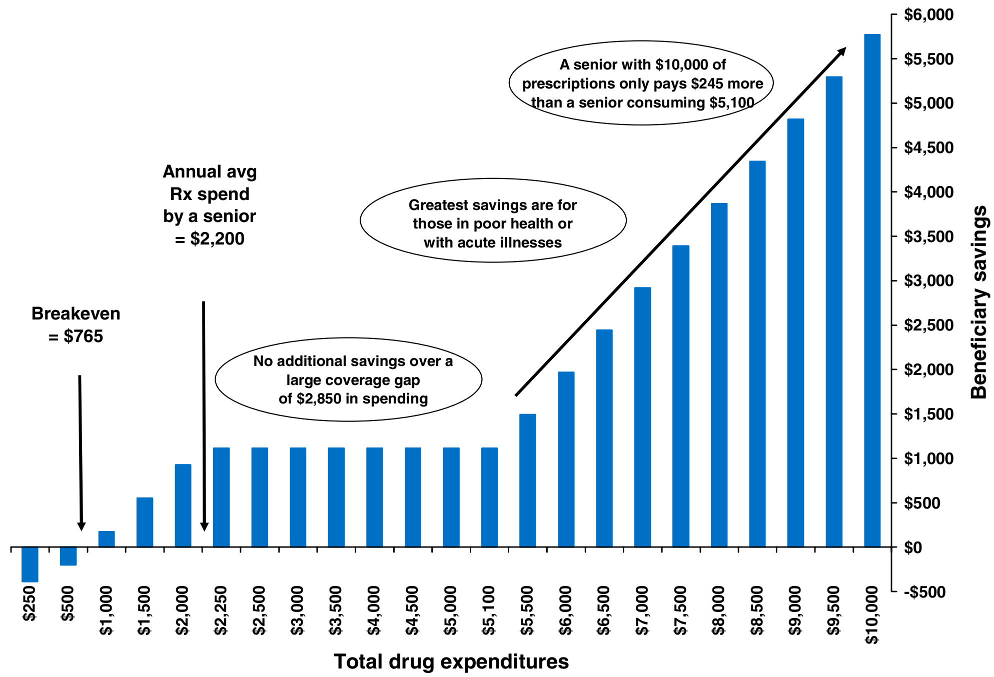
Exhibit 11: Cost-sharing arrangement
Percentage savings will be greater for those near the start of the coverage gap or in poor health



Source: CMS and Goldman Sachs Research.

Based on the average annual premium of $386 (versus previous estimate of $448), we calculate the breakeven point for seniors with standard coverage to be $765 versus our previous estimate of $810. Our analysis implies that seniors who purchase few prescriptions will receive a very modest benefit from MMA Part D.

Exhibit 12: Beneficiary savings
Breakeven point for Part D is roughly $765



Source: CMS and Goldman Sachs Research estimates.

What we now know: dual eligibles

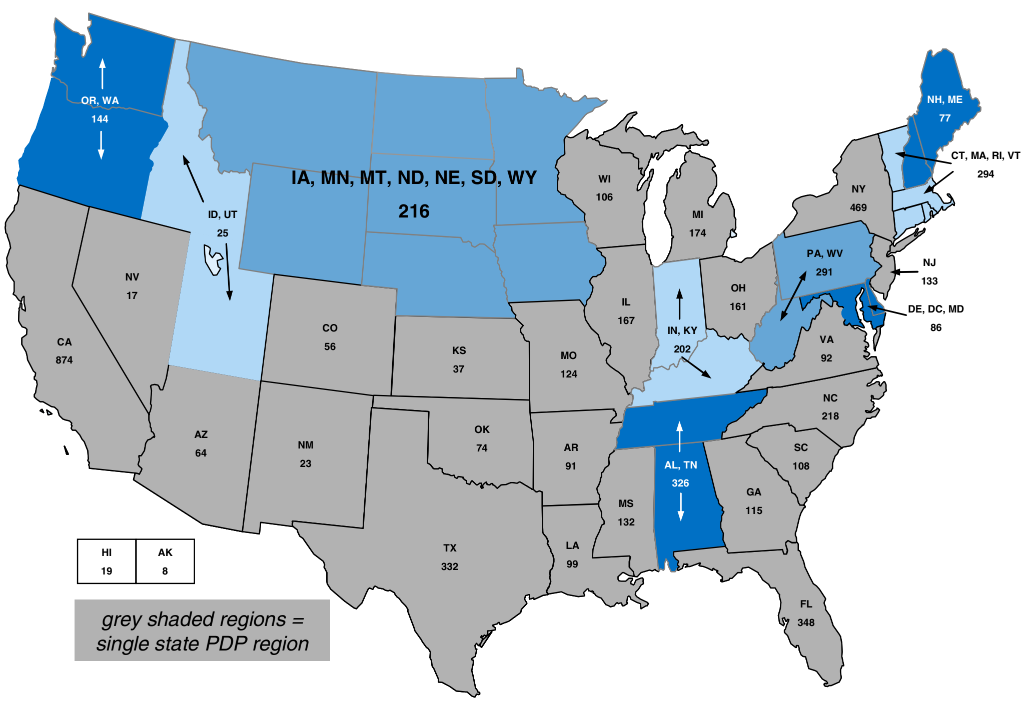
Although only about 15% of the total Part D-eligible population, the dual eligibles are important because those that do not sign up for a plan will be auto-enrolled into PDPs based on an algorithm developed by CMS. Plan-level data released by CMS over the past two weeks provides insight into the participants in each region and how competitive it will be for auto-enrollees. Because dual eligibles are auto-assigned to plans by CMS, their enrollment requires minimal incremental marketing and sign-up costs and likely carries a higher margin than open-enrollment Part D beneficiaries. Based on our analysis, the earnings impact from this portion of Part D enrollees is expected to be very modest, with Caremark benefiting the most among the big-three national PBMs.

Part D coverage specifics for dual eligibles

According to the Kaiser Family Foundation, 73% of dual eligibles have incomes below $10,000 and 52% are in poor/fair health.

Dual-eligible beneficiaries profile. Of an estimated 43 million Medicare beneficiaries eligible for Part D benefits, approximately 6.5 million are "dual eligibles" – low-income and/or disabled seniors who are enrolled in both Medicare and Medicaid (excluding "partial" dual eligibles who do not receive prescription drug coverage under Part D). The majority of dual eligibles have an annual income of less than $10,000.

Exhibit 13: Dual-eligible allocations by PDP region (thousands)
There are an estimated 5.7 million total dual eligibles (excluding MA) in 34 PDP regions across the country



Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Changes in coverage under MMA. Under previous legislation, dual eligibles relied on Medicaid (state-managed, income-based health benefits programs) for all of their prescription drug coverage. However, under the Medicare Modernization Act, their coverage will be shifted from Medicaid to Medicare. On January 1, 2006, all dual eligibles who have not yet selected a PDP will be automatically enrolled in one of the private plans selected by CMS to accept dual eligibles.

As per CMS's August 9, 2005 release, the national medical cost benchmark is $126.27 per member per month.

Dual eligibles are fully subsidized by the government: they have no annual deductible and pay no monthly premium (although most are still responsible for $1-$5 co-pays), but the level of this subsidy is limited. Established through a competitive bid process, a "low-income premium subsidy" benchmark varies by region and determines the maximum monthly premium reimbursed by the government. Anything in excess of this premium must be paid by the beneficiary. On August 9, 2005, CMS released low-income premium subsidy benchmarks for each region (presented in Exhibit 14). Similar to ordinary PDP plans for open enrollees, the government is additionally responsible for reimbursing the plan sponsor for 74.5% of the national medical cost benchmark.

Exhibit 14: Low-income premium subsidy benchmarks by region
Benchmarks reflect the competitive nature of each region

PDP region	States	Low-income premium subsidy	PDP region	States	Low-income premium subsidy	PDP region	States	Low-income premium subsidy
1	NH,ME	$36.09	13	MI	$33.22	24	KS	$33.44
2	CT,MA,RI,VT	$30.27	14	OH	$30.69	25	IA,MN,MT,ND,NE,SD, WY	$33.11
3	NY	$29.83	15	IN,KY	$35.69	26	NM	$25.95
4	NJ	$31.37	16	WI	$31.27	27	CO	$28.92
5	DE,DC,MD	$33.46	17	IL	$31.60	28	AZ	$24.62
6	PA,WV	$32.59	18	MO	$31.37	29	NV	$23.46
7	VA	$34.42	19	AR	$35.45	30	OR,WA	$30.60
8	NC	$36.30	20	MS	$36.39	31	ID,UT	$33.62
9	SC	$34.88	21	LA	$34.14	32	CA	$23.25
10	GA	$33.15	22	TX	$31.68	33	HI	$27.44
11	FL	$29.07	23	OK	$35.13	34	AK	$34.66
12	AL,TN	$32.33						

Source: Centers for Medicare and Medicaid Services.

Part D plans eligible to accept dual eligibles. Private sponsors who bid below the low-income premium subsidy benchmark are eligible to receive an allotment of dual eligibles. CMS will assign dual eligibles who have not made their own plan selection to qualified PDPs evenly on a random basis.

On September 23, 2005 CMS released a list of healthcare organizations that qualify to receive the dual-eligible auto enrollment. Exhibit 15 outlines the number of qualified plans in each region and highlights how competitive the bidding process was with each region having, on average, eight qualified plans.

Unicare is an affiliate of Wellpoint.

Exhibit 15: PDPs qualified to accept auto-enrolled dual eligibles (a)
Unicare qualified in all 34 regions; Humana, PacifiCare, United, and Wellcare in 33 regions

PDP region	States	PDPs qualified for dual eligibles	PDP region	States	PDPs qualified for dual eligibles	PDP region	States	PDPs qualified for dual eligibles
1	NH,ME	11	13	MI	13	24	KS	9
2	CT,MA,RI,VT	9	14	OH	8	25	IA,MN,MT,ND,NE,SD, WY	11
3	NY	11	15	IN,KY	11	26	NM	8
4	NJ	10	16	WI	12	27	CO	9
5	DE,DC,MD	14	17	IL	12	28	AZ	5
6	PA,WV	14	18	MO	8	29	NV	6
7	VA	13	19	AR	12	30	OR,WA	12
8	NC	11	20	MS	11	31	ID,UT	12
9	SC	14	21	LA	10	32	CA	7
10	GA	12	22	TX	14	33	HI	7
11	FL	6	23	OK	10	34	AK	7
12	AL,TN	8						

(a) As per CMS, Wellpoint subsidiaries Anthem, One Nation, and Unicare will share one allotment per region.

Source: Centers for Medicare and Medicaid Services.

Implications for the PBMs

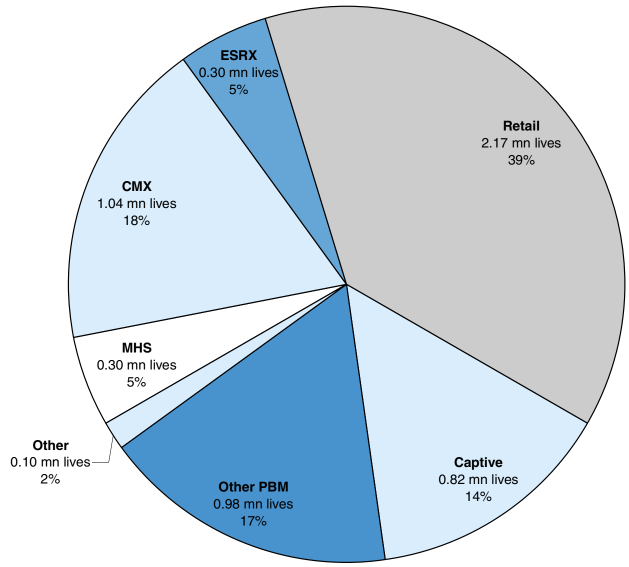
Market share estimates. During the planning and implementation stage of Part D, the three national PBMs, Caremark, Medco Health, and Express Scripts, announced plans to participate in the program by partnering with their managed care customers. In addition, Caremark and Medco Health have decided to take on risk and sponsor their own PDPs.

MCOs with captive PBMs include Aetna, Amerihealth Mercy, CIGNA, and Wellpoint.

Retailer PBM ownership:
1. Walgreen – Walgreen Health Initiatives
2. CVS – PharmaCare
3. Longs – RxAmerica

Based on information released by CMS on September 23, 2005, we measured the estimated impact of the dual-eligible auto-enrollment process on the PBM space, including national PBMs, captive PBMs affiliated with MCOs, PBMs owned by drug retailers, and other providers. Based on our analysis of managed care/PBM relationships in the context of Part D, some announced and some assumed based on historical relationships, we estimate how the dual-eligible population would be split among the participating PBM universe (Exhibit 16).

Exhibit 16: Estimated dual-eligible population market share
Dual-eligible lives enrolled



Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

The "Other PBM" category includes MemberHealth, a private PBM, which qualified to be a national PDP organization.

Based on our analysis, it appears that Caremark will have the largest share of dual-eligible lives with 1 million, or 18% of the total, due to its relationships with several managed care companies, as well as its own national PDP, SilverScript. PBMs owned by large drug retailers are likely to capture 39% of the total available lives, due primarily to Walgreen's alliances with United Healthcare and Wellcare and CVS's (PharmaCare) alliance with Universal American. On the opposite side of the spectrum, we do not expect Medco Health and Express Scripts to be major competitors in the dual-eligibles market. Medco Health appears to have secured few significant alliances in addition to its own PDP, while Express Scripts appears on this chart by virtue of our assumption that its relationship with Sierra Health with carry over to Part D administration.

FY2006 impact. Plan-level details released by CMS on September 30, 2005 allows for an even more detailed analysis of the benefits associated with the dual-eligible auto-enrollment process. For each of the three national PBMs, we estimate the revenue, pretax profit, and EPS impact resulting from the dual-eligible enrollment.

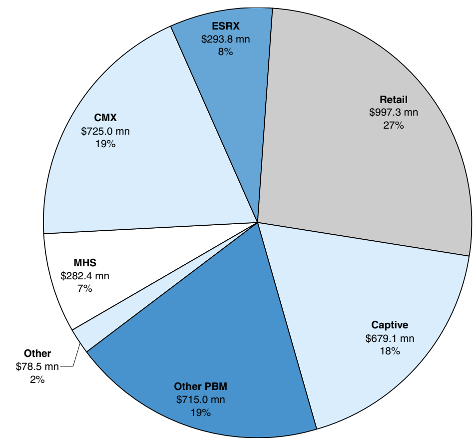
Potential revenues for each participant were derived through plan premiums reported by CMS. We assume each of the participating PBMs will incur additional costs to advertise and administer the plan, either on its own or through an affiliation. Exhibit 17 details some of the assumptions made in our analysis, and Exhibit 17 shows who could potentially gain the most (and the least) from dual-eligible auto-enrollment at the start of 2006 in revenue terms.

Exhibit 17: 2006 dual-eligible impact assumptions

Assumptions - Dual eligibles	
Population	1. Total of 5.7 million beneficiaries (excluding Medicare Advantage enrollees). 2. Every PDP gets equal number of enrollees. 3. All beneficiaries are auto-enrolled, assumed no self-selection.
Revenue	Per member per month revenues consist of the following: 1. 47.5% of benchmark ($126.27, excluding 27% reinsurance costs) plus 2. Lowest plan premium offered by a qualified sponsor in the region.
Pretax profit margins CMX MHS ESRX	1. For plans independently managed - 5.3%. 2. For plans managed for MCO customers - 2.6%.
Plan marketing & admin. costs CMX MHS ESRX	1. For plans independently managed - $300K/region. 2. For plans managed for MCO customers - $200K/region.

Source: Goldman Sachs Research estimates.

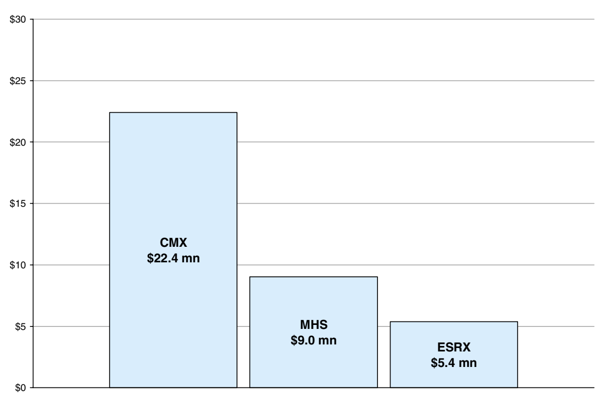
Exhibit 18: Dual-eligible revenue market share
Caremark and retailer affiliates appear to gain the most



Source: CMS, Goldman Sachs Research estimates.

FY2006 EPS impact. The impact of auto-enrollment of dual eligibles on pretax profit and EPS is expected to be very modest for the three national PBMs. Taking into account the likely administrative costs of $200,000-$300,000 per region, we estimate a FY2006 pretax profit impact of approximately $22 million for Caremark, $9 million for Medco Health, and $5 million for Express Scripts. Exhibit 18 summarizes the estimated incremental FY2006 pretax profit impact of dual-eligible auto-enrollment for Caremark, Medco Health, and Express Scripts.

Exhibit 19: FY2006 estimated pretax profit impact
Caremark converts leading market share into profits



Source: CMS, Goldman Sachs Research estimates.

Exhibit 20: Caremark's 2006 EPS sensitivity analysis
Likely EPS impact in the $0.03-$0.05 range

Caremark - EPS impact sensitivity analysis

		Pretax margin PMPM						
		2.0%	3.0%	4.0%	5.0%	6.0%	7.0%	8.0%
Fixed Costs per region ($, 000)	50	$0.02	$0.03	$0.04	$0.05	$0.06	$0.07	$0.07
	100	$0.01	$0.02	**$0.03**	**$0.04**	**$0.05**	$0.06	$0.07
	150	$0.01	$0.02	**$0.03**	**$0.04**	**$0.05**	$0.06	$0.07
	200	$0.01	$0.02	**$0.03**	**$0.04**	**$0.05**	$0.06	$0.07
	250	$0.01	$0.02	**$0.03**	**$0.04**	**$0.05**	$0.06	$0.07
	300	$0.01	$0.02	**$0.03**	**$0.03**	**$0.04**	$0.05	$0.06
	350	$0.00	$0.01	$0.02	$0.03	$0.04	$0.05	$0.06
	400	$0.00	$0.01	$0.02	$0.03	$0.04	$0.05	$0.06
	450	$0.00	$0.01	$0.02	$0.03	$0.04	$0.05	$0.06
	500	$0.00	$0.01	$0.02	$0.03	$0.04	$0.05	$0.06

Source: CMS, Goldman Sachs Research estimates.

Enrollment of dual eligibles is not likely to significantly impact FY2006 earnings for any of the three national PBMs (see Exhibits 20-22). The EPS impact varies depending on assumptions for pretax margin and additional administrative plan costs but is expected to be $0.03-$0.05 for Caremark and $0.01-$0.03 for Medco Health and Express Scripts.

Exhibit 21: Medco's 2006 EPS sensitivity analysis
Likely EPS impact in the $0.01-$0.03 range

Medco Health Solutions - EPS impact sensitivity analysis

Fixed Costs per region ($, 000)	Pretax margin PMPM	2.0%	3.0%	4.0%	5.0%	6.0%	7.0%	8.0%
	50	$0.01	$0.02	$0.02	$0.03	$0.03	$0.04	$0.05
	100	$0.01	$0.01	**$0.02**	**$0.03**	**$0.03**	$0.04	$0.04
	150	$0.01	$0.01	**$0.02**	**$0.02**	**$0.03**	$0.04	$0.04
	200	$0.00	$0.01	**$0.02**	**$0.02**	**$0.03**	$0.03	$0.04
	250	$0.00	$0.01	**$0.01**	**$0.02**	**$0.03**	$0.03	$0.04
	300	$0.00	$0.01	**$0.01**	**$0.02**	**$0.02**	$0.03	$0.04
	350	$0.00	$0.00	$0.01	$0.02	$0.02	$0.03	$0.03
	400	-$0.01	$0.00	$0.01	$0.01	$0.02	$0.03	$0.03
	450	-$0.01	$0.00	$0.00	$0.01	$0.02	$0.02	$0.03
	500	-$0.01	$0.00	$0.00	$0.01	$0.02	$0.02	$0.03

Source: CMS, Goldman Sachs Research estimates.

Exhibit 22: Express Scripts' 2006 EPS sensitivity analysis
Likely EPS impact in the $0.01-$0.03 range

Express Scripts - EPS impact sensitivity analysis

Fixed Costs per region ($, 000)	Pretax margin PMPM	1.1%	1.6%	2.1%	2.6%	3.1%	3.6%	4.1%
	50	$0.01	$0.02	$0.02	$0.03	$0.03	$0.04	$0.05
	80	$0.01	$0.02	$0.02	$0.03	$0.03	$0.04	$0.04
	110	$0.01	$0.01	**$0.02**	**$0.03**	**$0.03**	$0.04	$0.04
	140	$0.01	$0.01	**$0.02**	**$0.02**	**$0.03**	$0.04	$0.04
	170	$0.01	$0.01	**$0.02**	**$0.02**	**$0.03**	$0.03	$0.04
	200	$0.00	$0.01	**$0.02**	**$0.02**	**$0.03**	$0.03	$0.04
	220	$0.00	$0.01	**$0.01**	**$0.02**	**$0.03**	$0.03	$0.04
	240	$0.00	$0.01	$0.01	$0.02	$0.03	$0.03	$0.04
	260	$0.00	$0.01	$0.01	$0.02	$0.02	$0.03	$0.04
	280	$0.00	$0.01	$0.01	$0.02	$0.02	$0.03	$0.04

Source: CMS, Goldman Sachs Research estimates.

What we now know: open enrollees

Approximately 19 million seniors, or 46% of the Part D-eligible population, are expected to participate in open enrollment. Plan sponsors will have to actively market to seniors to encourage them to enroll in their plan. There are a total of 65 PDP sponsors, including 10 national sponsors, offering a total of 1,429 plans across the regions. While most offer three-tier co-pays and mail order and coverage of approximately 90% of the top-100 drugs used by seniors, monthly premiums, deductibles, and coverage in the "doughnut hole" vary greatly. It is unclear what the primary drivers will be for seniors in their decision-making process: lowest monthly costs, greatest protection, familiarity with plan sponsor, or marketing efforts.

There is significant competition for open enrollees with 65 PDP sponsors across 34 regions, including 10 national PDP sponsors (see Exhibit 23).

Exhibit 23: Part D sponsor and plan statistics
National averages

PDP Summary statistics	
Regions*	34
PDP Sponsors	65
Nat'l PDP Sponsors	10
PDPs	1,429

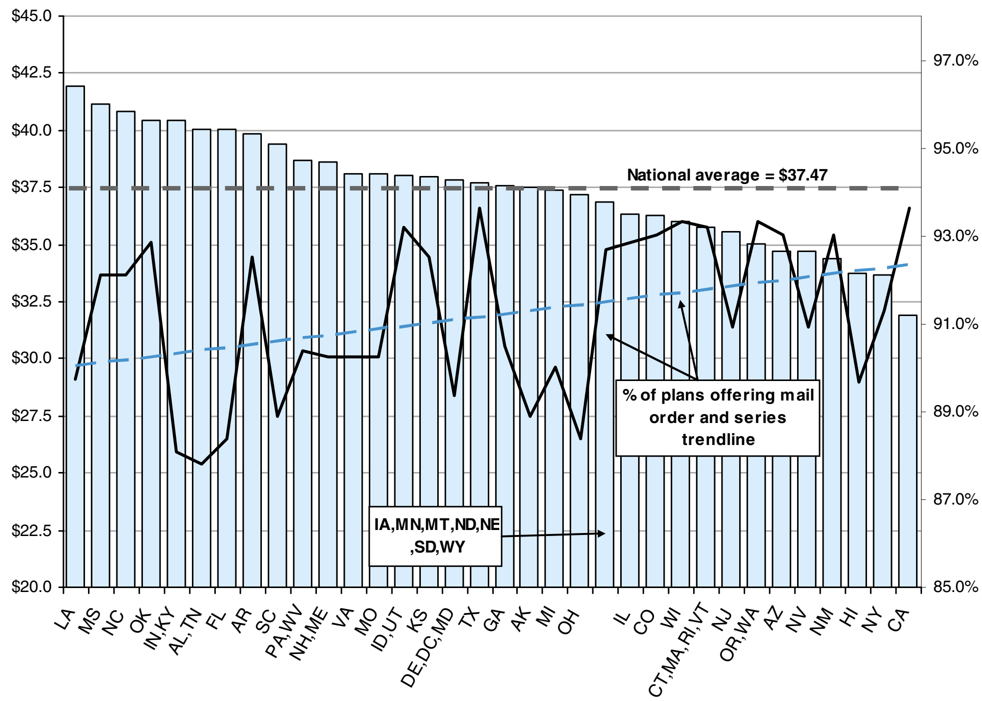
* excluding non-states

Average plan statistics	
Monthly premium (unweighted)	$37.47
Zero-deductible plans (%)	58.5%
Plans with 3-tier copays (%)	89.7%
Plans offering mail-order	91.2%
Top 100 drugs in formulary	89.9

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Exhibit 24 shows the average monthly premium by PDP regions. Interestingly, California, a state that has high MA enrollment, has the lowest average monthly premium. This could imply that plan participants are aggressively pricing their plans in the region to sign up seniors and then try to subsequently convert them to MA. Based on this exhibit it appears that plans are using mail order to reduce costs so that they can reduce monthly premiums.

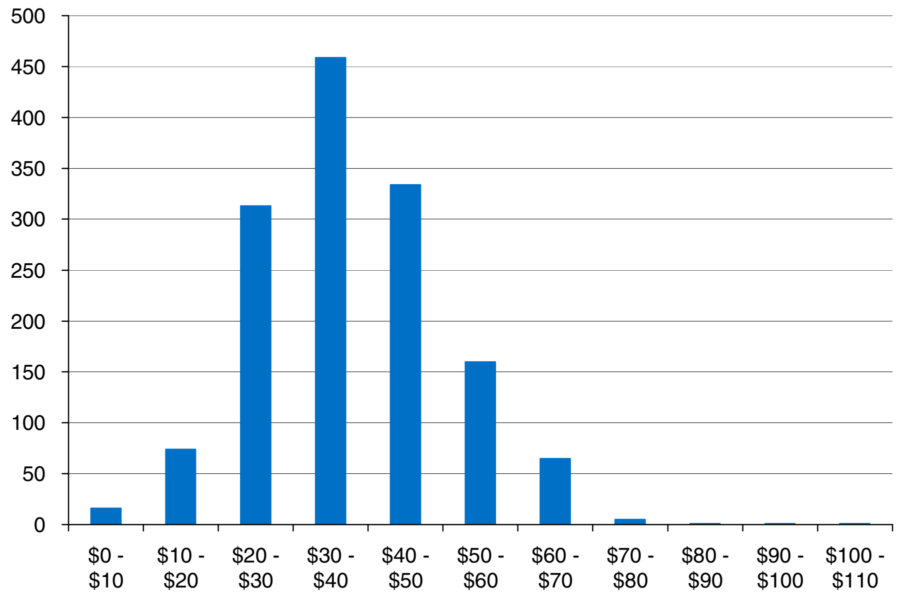
Exhibit 24: Average monthly premium by PDP region
higher mail-order penetration rates appear correlated with lower premiums



Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

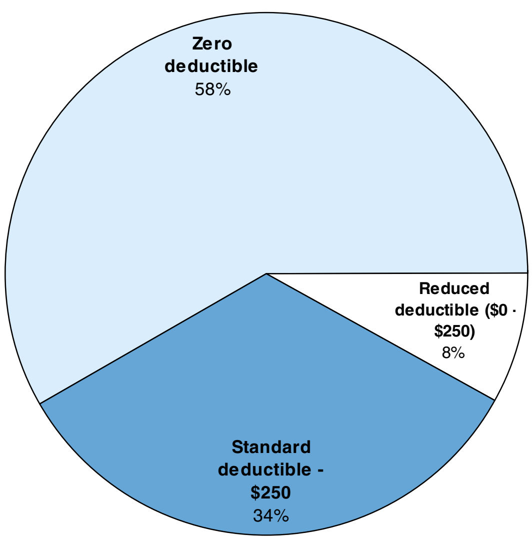
Plans appear to use monthly premiums and deductibles to compete for senior enrollment. Monthly premiums vary widely – from less than $2 to more than $100 per month – but on average fall in a range of $20 to $40 (Exhibit 25). Only 34% of plans will offer the standard $250 deductible while 58% will have no deductible (Exhibit 26). Not surprising, 91% will offer mail-order service that will allow seniors to purchase a three-month supply at a reduced cost of purchasing two monthly prescriptions at retail (Exhibit 27).

Exhibit 25: Distribution of PDP drug plan premiums
A wide range of drug plan premiums: from less than $2 to over $100 per month



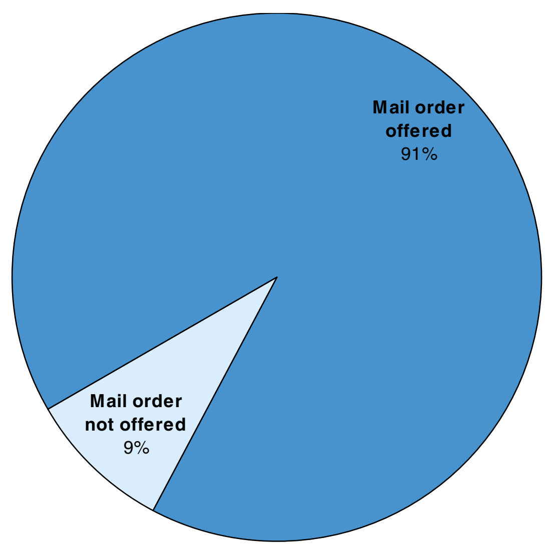
Source: CMS and Goldman Sachs Research estimates.

Exhibit 26: PDP plan structure: deductibles
Most plans have either $0 or a $250 deductible



Source: CMS, Goldman Sachs Research estimates.

Exhibit 27: PDP plan structure: mail order
Vast majority of plans offer mail-order option



Source: CMS, Goldman Sachs Research estimates.

Exhibit 28 provides a summary of plan attributes by region. On average each region has 17 providers with 42 plans to choose from.

Exhibit 28: Summary PPD plan statistics by region
Regional averages

PDP Region	States	# of Providers	# of Plans	Avg premium	Drug Deductible			% tiered copay for drugs	Type of Additional Coverage Offered in Coverage Gap		% Mail order offered	Average number of top 100 drugs on formulary
					Zero (%)	Reduced (%)	Standard (%)		Generics only (%)	Generics and brands (%)		
1	NH,ME	16	41	$38.64	58.5%	7.3%	34.1%	51.2%	14.6%	0.0%	90.2%	89.5
2	CT,MA,RI,VT	17	44	$35.77	63.6%	6.8%	29.5%	93.2%	13.6%	2.3%	93.2%	89.7
3	NY	20	46	$33.68	54.3%	10.9%	34.8%	82.6%	10.9%	2.2%	91.3%	89.5
4	NJ	17	44	$35.55	56.8%	6.8%	36.4%	86.4%	11.4%	2.3%	90.9%	90.1
5	DE,DC,MD	18	47	$37.84	55.3%	6.4%	38.3%	89.4%	10.6%	2.1%	89.4%	90.0
6	PA,WV	19	52	$38.69	57.7%	9.6%	32.7%	88.5%	11.5%	3.8%	90.4%	90.1
7	VA	16	41	$38.12	56.1%	7.3%	36.6%	90.2%	12.2%	2.4%	90.2%	90.0
8	NC	16	38	$40.86	57.9%	7.9%	34.2%	89.5%	15.8%	2.6%	92.1%	89.6
9	SC	18	45	$39.39	53.3%	6.7%	40.0%	84.4%	11.1%	2.2%	88.9%	90.2
10	GA	18	42	$37.60	57.1%	7.1%	35.7%	88.1%	14.3%	2.4%	90.5%	90.0
11	FL	18	43	$40.02	58.1%	11.6%	30.2%	90.7%	11.6%	7.0%	88.4%	89.6
12	AL,TN	16	41	$40.05	56.1%	4.9%	39.0%	82.9%	12.2%	2.4%	87.8%	89.7
13	MI	17	40	$37.41	57.5%	7.5%	35.0%	90.0%	12.5%	2.5%	90.0%	90.5
14	OH	17	43	$37.17	58.1%	7.0%	34.9%	88.4%	14.0%	2.3%	88.4%	90.3
15	IN,KY	16	42	$40.42	59.5%	7.1%	33.3%	90.5%	14.3%	2.4%	88.1%	90.3
16	WI	17	45	$36.04	64.4%	6.7%	28.9%	95.6%	17.8%	2.2%	93.3%	90.7
17	IL	16	42	$36.35	59.5%	9.5%	31.0%	90.5%	11.9%	2.4%	92.9%	90.5
18	MO	15	41	$38.08	61.0%	7.3%	31.7%	92.7%	14.6%	2.4%	90.2%	90.3
19	AR	15	40	$39.84	60.0%	7.5%	32.5%	92.5%	12.5%	2.5%	92.5%	90.0
20	MS	15	38	$41.15	60.5%	7.9%	31.6%	92.1%	13.2%	2.6%	92.1%	89.9
21	LA	16	39	$41.97	61.5%	7.7%	30.8%	92.3%	12.8%	2.6%	89.7%	89.7
22	TX	20	47	$37.68	57.4%	6.4%	36.2%	89.4%	10.6%	2.1%	93.6%	87.9
23	OK	23	42	$40.47	59.5%	9.5%	31.0%	95.2%	14.3%	2.4%	92.9%	90.3
24	KS	15	40	$37.94	62.5%	7.5%	30.0%	95.0%	15.0%	2.5%	92.5%	90.2
25	IA,MN,MT,ND,NE,SD,WY	18	41	$36.85	56.1%	9.8%	34.1%	90.2%	12.2%	4.9%	92.7%	90.3
26	NM	17	43	$34.36	60.5%	9.3%	30.2%	93.0%	11.6%	2.3%	93.0%	90.2
27	CO	17	43	$36.25	60.5%	7.0%	32.6%	93.0%	14.0%	2.3%	93.0%	90.0
28	AZ	18	43	$34.74	58.1%	7.0%	34.9%	93.0%	11.6%	2.3%	93.0%	89.6
29	NV	17	44	$34.70	56.8%	6.8%	36.4%	90.9%	13.6%	2.3%	90.9%	89.8
30	OR,WA	20	45	$35.06	55.6%	6.7%	37.8%	91.1%	11.1%	2.2%	93.3%	89.8
31	ID,UT	18	44	$38.06	52.3%	9.1%	38.6%	90.9%	11.4%	2.3%	93.2%	89.9
32	CA	18	47	$31.95	59.6%	6.4%	34.0%	91.5%	12.8%	2.1%	93.6%	89.2
33	HI	12	29	$33.75	58.6%	10.3%	31.0%	96.6%	17.2%	0.0%	89.7%	89.1
34	AK	11	27	$37.50	63.0%	11.1%	25.9%	100.0%	18.5%	0.0%	88.9%	89.4
	SUM	**577**	**1,429**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
	AVERAGE	**17.0**	**42.0**	**$37.47**	**58.5%**	**7.9%**	**33.6%**	**89.7%**	**13.2%**	**2.4%**	**91.2%**	**89.9**

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Exhibits 29 and 30 provide snapshots of the attributes of the regions with the lowest and highest monthly premiums.

Exhibit 29: Largest seven PDP regions with the lowest monthly premiums
CA and NY likely to have low premiums due to the competitive nature of the markets

PDP Region	States	# of Providers	# of Plans	Avg premium	Drug Deductible			% tiered copay for drugs	Type of Additional Coverage Offered in Coverage Gap		% Mail order offered	Average number of top 100 drugs on formulary
					Zero (%)	Reduced (%)	Standard (%)		Generics only (%)	Generics and brands (%)		
32	CA	18	47	$31.95	59.6%	6.4%	34.0%	91.5%	12.8%	2.1%	93.6%	89.2
3	NY	20	46	$33.68	54.3%	10.9%	34.8%	82.6%	10.9%	2.2%	91.3%	89.5
33	HI	12	29	$33.75	58.6%	10.3%	31.0%	96.6%	17.2%	0.0%	89.7%	89.1
26	NM	17	43	$34.36	60.5%	9.3%	30.2%	93.0%	11.6%	2.3%	93.0%	90.2
29	NV	17	44	$34.70	56.8%	6.8%	36.4%	90.9%	13.6%	2.3%	90.9%	89.8
28	AZ	18	43	$34.74	58.1%	7.0%	34.9%	93.0%	11.6%	2.3%	93.0%	89.6
30	OR,WA	20	45	$35.06	55.6%	6.7%	37.8%	91.1%	11.1%	2.2%	93.3%	89.8
	SUM	122	297	-	-	-	-	-	-	-	-	-
	AVERAGE	17.4	42.4	$34.03	57.6%	8.2%	34.2%	91.2%	12.7%	1.9%	92.1%	89.6

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Exhibit 30: Largest seven PDP regions with the highest monthly premiums

PDP Region	States	# of Providers	# of Plans	Avg premium	Drug Deductible			% tiered copay for drugs	Type of Additional Coverage Offered in Coverage Gap		% Mail order offered	Average number of top 100 drugs on formulary
					Zero (%)	Reduced (%)	Standard (%)		Generics only (%)	Generics and brands (%)		
21	LA	16	39	$41.97	61.5%	7.7%	30.8%	92.3%	12.8%	2.6%	89.7%	89.7
20	MS	15	38	$41.15	60.5%	7.9%	31.6%	92.1%	13.2%	2.6%	92.1%	89.9
8	NC	16	38	$40.86	57.9%	7.9%	34.2%	89.5%	15.8%	2.6%	92.1%	89.6
23	OK	23	42	$40.47	59.5%	9.5%	31.0%	95.2%	14.3%	2.4%	92.9%	90.3
15	IN,KY	16	42	$40.42	59.5%	7.1%	33.3%	90.5%	14.3%	2.4%	88.1%	90.3
12	AL,TN	16	41	$40.05	56.1%	4.9%	39.0%	82.9%	12.2%	2.4%	87.8%	89.7
11	FL	18	43	$40.02	58.1%	11.6%	30.2%	90.7%	11.6%	7.0%	88.4%	89.6
	SUM	120	283	-	-	-	-	-	-	-	-	-
	AVERAGE	17.1	40.4	$40.70	59.0%	8.1%	32.9%	90.5%	13.5%	3.1%	90.2%	89.9

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

At the plan level, there are significant differences between cost to enrollees and the benefits they will receive. Exhibits 31 and 32 highlight the attributes of the ten lowest-premium and ten highest-premium plans. We note that the ten lowest-premium plans are all offered by Humana. Prescription Pathway (Universal American) offers five of the top-ten highest-premium plans. While Prescription Pathway's plans have zero deductibles, they do not provide any coverage in the "doughnut hole."

Exhibit 31: Top-ten PDP plans with the lowest monthly premiums
Humana sponsors top-35 PDPs with the lowest premium and 47 of the top-50 plans with the lowest premium

PDP Region	State	Sponsor	Plan	Premium	Drug Deductible			Tiered copay for drugs	Type of addl coverage in Coverage Gap		Mail order offered	Average number of top 100 drugs on formulary
					Zero	Reduced	Standard		Generics only	Generics and brands		
25	IA	Humana Inc.	Humana PDP Standard S5884-083	$1.87			x				x	97.0
3	NY	Humana Insurance C. of NY	Humana PDP Standard S5552-003	$4.10			x				x	97.0
4	NJ	Humana Inc.	Humana PDP Standard S5884-062	$4.43			x				x	97.0
25	IA	Humana Inc.	Humana PDP Enhanced S5884-023	$4.91	x			x			x	97.0
32	CA	Humana Inc.	Humana PDP Standard S5884-090	$5.41			x				x	97.0
28	AZ	Humana Inc.	Humana PDP Standard S5884-086	$6.14			x				x	97.0
31	ID	Humana Inc.	Humana PDP Standard S5884-089	$6.33			x				x	97.0
29	NV	Humana Inc.	Humana PDP Standard S5884-087	$6.42			x				x	97.0
5	DE	Humana Inc.	Humana PDP Standard S5884-063	$6.44			x				x	97.0
30	OR	Humana Inc.	Humana PDP Standard S5884-088	$6.93			x				x	97.0
			PERCENTAGE OF TOTAL	-	10%	0.0%	90.0%	10.0%	0.0%	0.0%	100.0%	-
			AVERAGE	$5.30	-	-	-	-	-	-	-	97.0

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Exhibit 32: Top-ten PDP plans with the highest monthly premiums
Universal American's Marquette plans occupy five of the top-ten positions

PDP Region	State	Sponsor	Plan	Premium	Drug Deductible			Tiered copay for drugs	Type of addl coverage in Coverage Gap		Mail order offered	Average number of top 100 drugs on formulary
					Zero	Reduced	Standard		Generics only	Generics and brands		
11	FL	Universal Health Care, Inc.	Masterpiece Rx Choice	$104.89	x			x		x	x	76.0
25	IA	MedicareBlue Rx	MedicareBlue Rx Option 3	$99.90	x			x		x	x	96.0
3	NY	HealthNow New York, Inc.	SmartHealth RX	$85.02			x				x	88.0
10	GA	Humana Inc.	Humana PDP Complete S5884-038	$73.17	x			x		x	x	97.0
23	OK	Prescription Pathway	Marquette National Enhanced #2 Reg 23	$70.79	x			x			x	96.0
15	IN	Prescription Pathway	Marquette National Enhanced #2 Reg 15	$70.72	x			x			x	96.0
20	MS	Prescription Pathway	Marquette National Enhanced #2 Reg 20	$70.59	x			x			x	96.0
21	LA	Prescription Pathway	Marquette National Enhanced #2 Reg 21	$70.59	x			x			x	96.0
12	AL	Prescription Pathway	Marquette National Enhanced #2 Reg 12	$69.98	x			x			x	96.0
21	LA	Humana Inc.	Humana PDP Complete S5884-049	$69.92	x			x		x	x	97.0
			PERCENTAGE OF TOTAL	-	90%	0.0%	10.0%	90.0%	0.0%	40.0%	100.0%	-
			AVERAGE	$78.56	-	-	-	-	-	-	-	93.4

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Conclusion

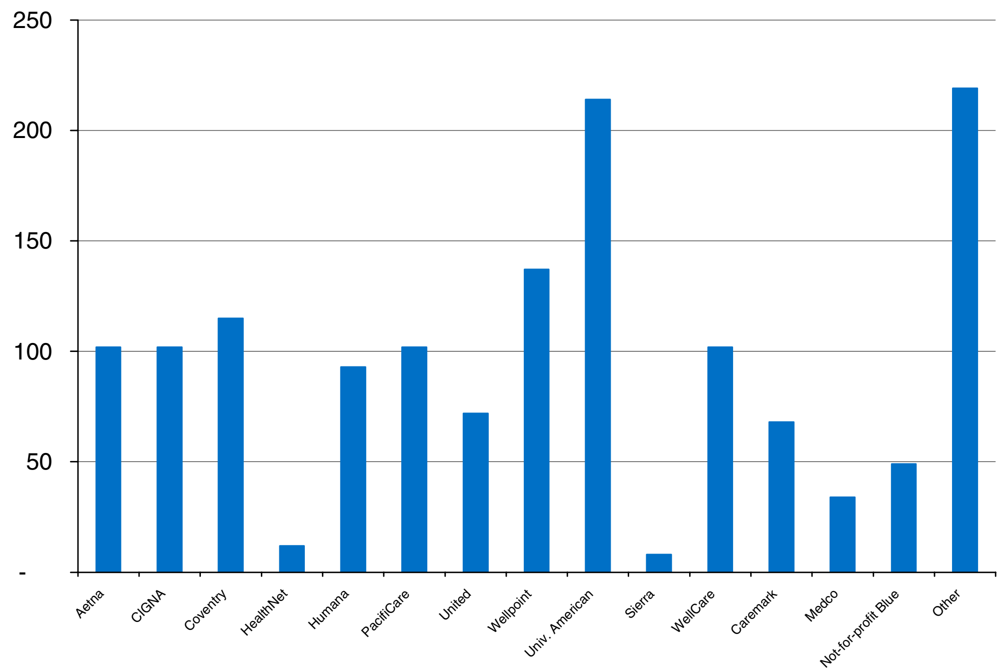
The bulk of CMS marketing and promotional spending will likely be focused on seniors eligible for open enrollment. These fee-for-service Medicare beneficiaries are likely to carefully scrutinize the plans to determine if the insurance elements of the plans are attractive economically. Their willingness to participate will largely determine the perceived success of the program, a determination that will weigh heavily in the mid-term election. Although the economics have grown incrementally more attractive, we still see a slow build, a pattern frustrating to policymakers and one likely to undermine Part D's impact in 2006.

Prescription drug plan sponsors

We reviewed the characteristics of prescription drug plans and their sponsors based on the recent CMS disclosures. Reflecting both the benefits of experience and funding, public managed care companies will account for 75% of all drug plans being offered. PBMs Caremark and Medco will offer 102 plans on a stand-alone basis in addition to supporting managed care companies.

Exhibit 33 shows that 75% of the plans being offered will be by public managed care companies. Universal American (UHCO) will offer the greatest number of plans with 214 plans, followed by WellPoint with 137 plans.

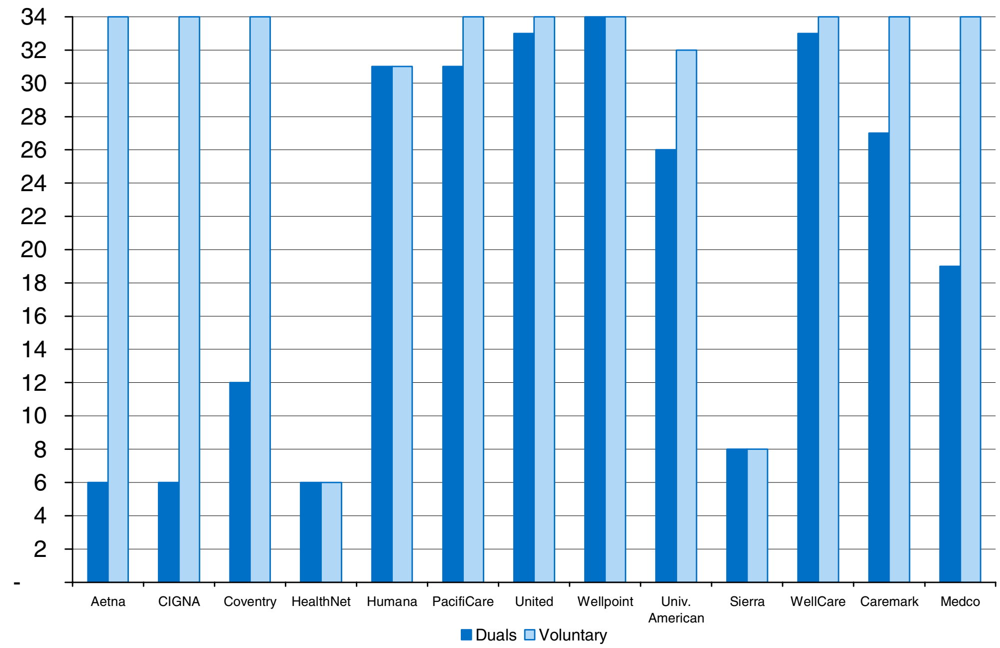
Exhibit 33: Total number of drug plans offered (all regions, all types)
Universal American (UHCO) will offer the greatest number of drug plans



Source: CMS and Goldman Sachs Research estimates.

Exhibit 34 shows managed care and PBM participation for dual eligibles and open enrollment. WellPoint is the only company that will have both dual-eligible and voluntary participation across all 34 PDP regions.

Exhibit 34: Participating regions for dual-eligible and voluntary drug plans by company
Broad participation across the 34 PDP regions

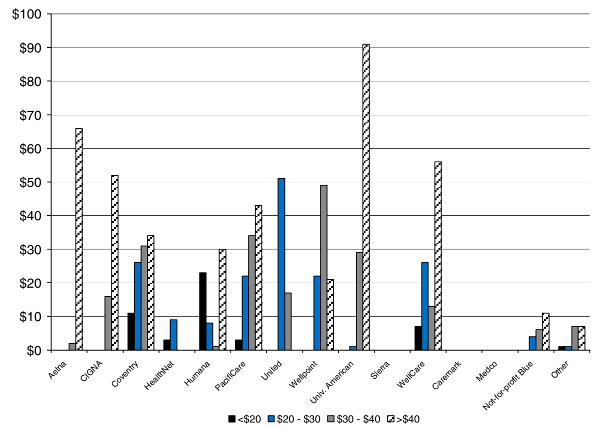


Source: CMS and Goldman Sachs Research.

PDP pricing

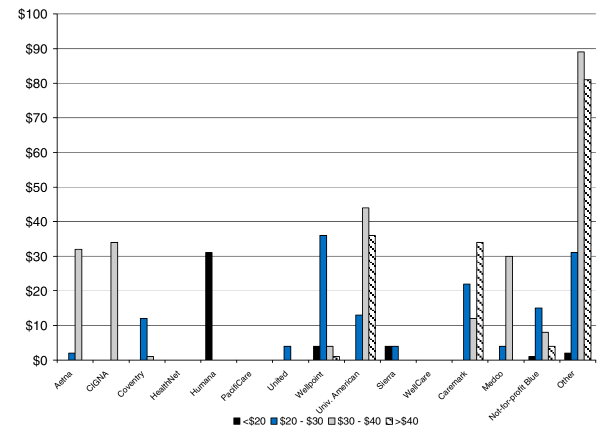
Based on our analysis it appears that pricing was competitive between monthly premiums and deductibles. Approximately 58% of all drug plans offered are zero-deductible plan. For example, Humana will offer zero-deductible plans with premiums below $20 in all of its 31 drug regions and accounts for three-quarters of all zero-deductible drug plans with premiums below $20. For public managed care companies, 20% of drug plans offered are zero deductible with premiums below $30. In contrast, for independent PBMs and other companies, only 2% of drug plans offered are zero deductible with premiums below $30 (Exhibits 35 and 36).

Exhibit 35: Distribution of zero-deductible drug plans
Humana, Coventry, and WellCare will offer the lowest-price drug plans



Source: CMS and Goldman Sachs Research.

Exhibit 36: Distribution of deductible drug plans
Independent PBMs and "other plans" appear to be pricing more conservatively

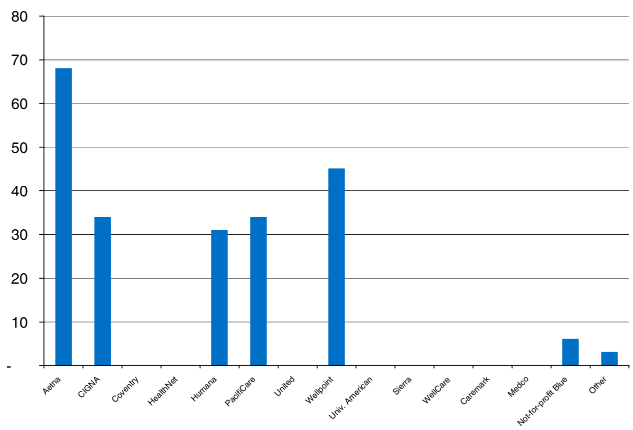


Source: CMS and Goldman Sachs Research.

PDP coverage

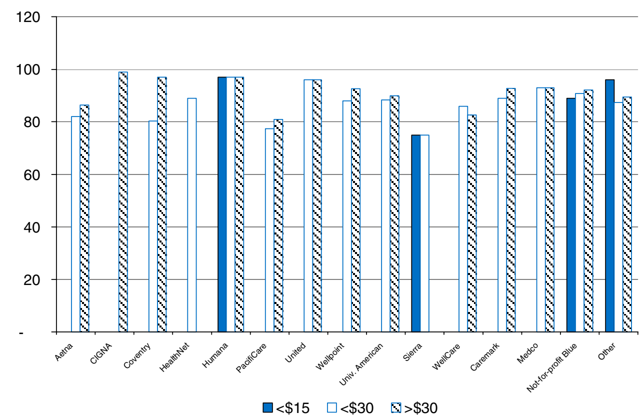
Coverage varies greatly among plans. One option is coverage for the "doughnut hole." Approximately 15% of all drug plans will offer coverage through the $2,250-$5,000 coverage gap where no coverage is provided under the standard plan. Doughnut hole coverage will be generic-only, except for Humana plans that cover both brand and generic. Drug coverage will be fairly comprehensive across all plans, with 90 of the top-100 drugs in formulary on average. Humana, which in general offers many of the lowest monthly premiums, will offer 97 of the top-100 drugs for premiums below $15. Our analysis found CIGNA's formulary to be the least restrictive but at the cost of higher premiums. In contrast, Sierra's formulary appears to be the most restrictive (Exhibits 37 and 38).

Exhibit 37: Number of PDP drug plans with doughnut hole coverage
Aetna, CIGNA, Humana, PacifiCare, and WellPoint offer doughnut hole coverage



Source: CMS and Goldman Sachs Research.

Exhibit 38: Number of top-100 drugs offered on formulary by company and premium
Humana's formulary appears the most generous relative to premium levels



Source: CMS and Goldman Sachs Research.

Conclusion

The average PDP region will have 42 plans offered. We expect a significant amount of share to accrue to known brands (or plans marketed through visible co-promoters) due to the inability of plans to market cost-effectively to seniors in a narrow enrollment period. We think this puts large managed care plans and drug retailers (as market agents) in a commanding position to gain a disproportionate share of the open enrollees. This dynamic could be an additional headwind for PBMs given that most national plans either have a captive PBM or have partnered with a national drug retailer.

Medicare Advantage: the privatization of Medicare

Medicare Advantage (MA) is the private-sector managed care alternative to government-directed fee-for-service Medicare. We expect at least 1 million seniors to switch to MA from traditional Medicare next year, a significant earnings growth driver for managed care next year.

Under the most optimistic scenario, MA may represent the end game for Medicare and an unprecedented multiyear growth opportunity for managed care.

MA expected to drive two-thirds of Medicare-derived earnings next year

Using our baseline forecast of 1 million seniors joining MA plans next year, we estimate that MA growth will drive two-thirds of the Medicare-derived earnings growth for our covered companies in 2006.

With 36 million beneficiaries in traditional Medicare and with MA reimbursement at over $10,000 per senior per year (about 10X the per-member revenues of PDP), we view Medicare Advantage as a more significant and longer-term growth opportunity for managed care versus stand-alone PDP.

The adoption rate of MA will be a key determinant in our sector outlook

We look to the 1H2006 rate of conversion of seniors to MA as a key determinant in our longer-term sector view. An initially high conversion rate would imply that multiyear growth is more likely, leading to mitigation of commercial cyclical risk to the industry.

Under the most optimistic scenario, MA may represent the end game for Medicare and an unprecedented multiyear growth opportunity for managed care. At the same time, the offsetting risk for the industry would be that rapid MA growth would make a growing proportion of earnings dependent on the pricing power of a single customer: the government.

We highlight that sustained conversion of seniors to MA at a rate of about 2 million (our high-end forecast) would generate more than $20 billion in new industry revenues per year (about 10% of industry-wide revenues).

Rapid growth of MA would be less favorable for PBMs

For managed care, we view the PDP lives as high potential new customers for full-scope MA health plan products (HMO and PPO), which we believe will generate a somewhat higher profit margin (4%-5% pretax) and significantly higher profit per member (10X-15X more than under PDP, on a per-member basis).

However, for PBM and other PDP-only participants, MA programs could take potential open enrollees out of the pool of seniors by bundling medical and drug benefits. Furthermore, we believe some managed care companies may be willing to grow PDP enrollment as a loss leader to lure seniors into their MA programs.

The conversion rate to MA for 2006 likely to accelerate but remains uncertain

Although MA enrollment has accelerated so far this year (we estimate that more than 500,000 will join MA plans this year, up from 225,000 in 2004), it remains unclear how much the MA conversion rate will climb next year.

For 2006, seniors will have significantly expanded access to MA plan options, including the newer PPO and private fee-for-service options. The managed care industry is gearing up for an accelerated marketing push next year.

MA plans will also represent a more streamlined source of coverage as opposed to the alternative of buying separate Medicare drug and Medicare Supplemental ("Medigap") coverage plans. In addition, we highlight that zero drug premium MA plans will be available to seniors in 44 states.

At the same time, it remains unclear how MA enrollment may be impacted by the availability of a drug benefit alongside traditional Medicare, given that drug coverage has historically been a key factor in seniors joining MA plans.

Meanwhile, phase-in of the new one-year "lock in" provision next year (allowing seniors to switch plans only once per year) could dampen MA enrollment as well given that the ability to switch back to traditional Medicare at any time has historically represented a selling point for Medicare HMOs (i.e., the pitch to seniors being "try the HMO, take advantage of the enhanced benefits, and you can switch back to Medicare at any time if you don't like it").

Sustained migration to MA will require a sustained political consensus

Sustained migration to MA will require a political consensus around the future of Medicare that is currently lacking. The Bush Administration seeks to double MA enrollment to about 12 million by the end of the decade from 6 million today. However, what remains unclear is how many seniors in traditional Medicare are prepared to voluntarily switch to MA plans and accept greater restrictions in return for enhanced benefits and lower cost-sharing.

Massive migration to MA may require significantly greater incentives to switch in terms of greater benefit levels under MA, which would likely be unaffordable, or disincentives to remain in traditional Medicare, which is not politically supportable at present. We forecast that MA enrollment will grow to 8.5 million by 2009 from 6 million at present, which is a mid-point between the Bush Administration goal and the CBO estimate.

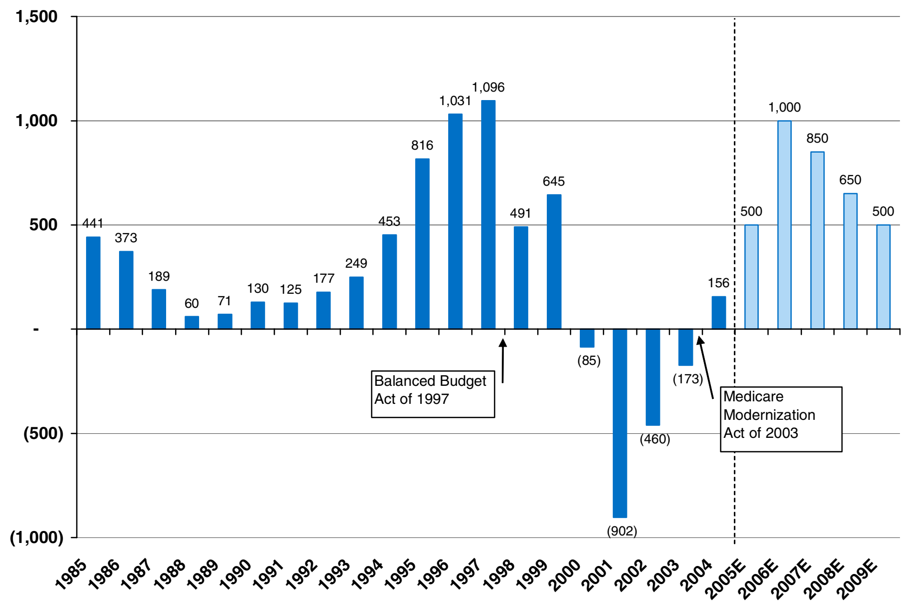
Our baseline forecast assumes that about 1 million seniors will switch to MA plans in 2006, with conversion decelerating to about 600,000 per year by 2010 as the industry confronts diminishing returns in terms of willingness to switch from traditional Medicare. Our baseline forecast represents a midpoint between the Bush Administration's goal and the current CBO estimate.

Background on Medicare Advantage

The Medicare HMO program – renamed "Medicare+Choice" (M+C) in 1997 and again renamed to "Medicare Advantage" (MA) in 2003 – was created by Congress in the early 1980s as a private-sector, managed care alternative to the traditional Medicare fee-for-service program. The MA program refers to both Medicare HMOs and the newer MA plan alternatives of PPO and private fee-for-service (PFFS) programs.

Medicare HMO enrollment grew rapidly under favorable reimbursement to managed care companies from the mid-1980s through the mid-1990s. Enrollment then declined following reimbursement cuts under the Balanced Budget Act of 1997 but has rebounded with greater managed care participation that has followed the reimbursement increases under the Medicare Modernization Act of 2003 (i.e., the Medicare drug benefit legislation).

Exhibit 39: Medicare Advantage enrollment (all products)
1985-2009E



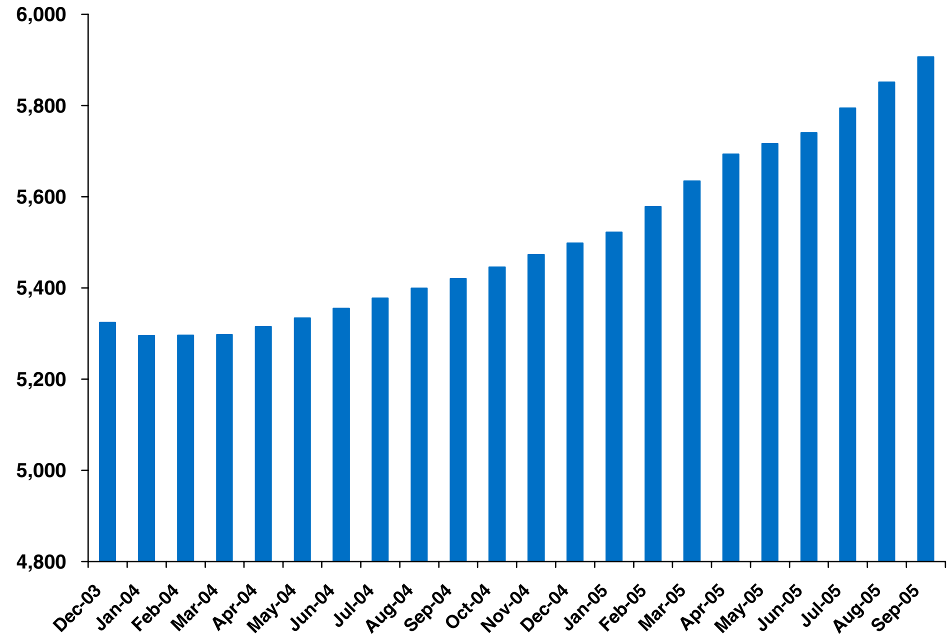
Source: CMS.

In some ways, the program has become a refuge for lower-income seniors, with more than one-third of MA beneficiaries having an annual income of less than $20,000. MA provides an affordable means of obtaining some coverage for prescription drugs that was not historically covered under the traditional Medicare program.

MA health plans offer better coverage at a lower cost. To entice seniors to enroll, Medicare HMOs offer more comprehensive coverage and lower out-of-pocket costs than traditional Medicare.

MA health plans are paid a fixed per-member premium. Under such arrangements, an MA health plan receives a set monthly payment from the government per enrolled participant (as high as $1,000 per enrollee per month or more in some parts of the country) and in return provides the participant with comprehensive medical care. The MA plan may also choose to require an additional member-paid premium. In return for the premium, the MA plan is responsible for providing all necessary medical care through its contracted network of doctors and hospitals. MA plans earn a profit by reducing medical trend through encouraging preventive care, managing hospital stays, and negotiating discounts from providers.

Exhibit 40: Medicare Advantage enrollment (all products 12/03-9/05)
Expect to add 0.5 million lives in 2005 and 1.0 million in 2006; in millions



Source: CMS.

Medicare Advantage provides significant opportunity under MMA Part D

We estimate that the expansion in Medicare coverage could generate $30 billion in new revenues and $1.2 billion in new pretax profit in 2006. Of the new profit generated, we expect covered managed care companies to capture $700-$800 million in new pretax profit on a base of $17 billion in 2005. Medicare Advantage is the bigger profit opportunity, particularly after 2006 when we expect it to drive 75% or higher growth in Medicare profit.

Exhibit 41: Medicare Rx (MA + PDP) expected to drive $1.2 billion in new profit in 2006

	Medicare Advantage	Medicare PDP	Total
Size (millions of lives) - 2005	5.9	-	
Size (millions of lives) - 2006E	7.0	19.0	
Revenue per member per month	$800	$85	
Profit margin (pretax)	6%	3%	
Profit per member per month	$50	$3	
New revenue - 2006 ($M)	10,560	19,380	29,940
New pretax profit - 2006 ($M)	**634**	**581**	**1,215**

Source: Company data and Goldman Sachs Research estimates.

Sustainability of favorable Medicare reimbursement is a key risk

Although the outlook for Medicare expansion is very bullish at present, Medicare reimbursement to managed care will likely become less favorable over the next several years given Medicare fiscal pressures and the uncertainty surrounding political support for Medicare privatization generally. However, while the risks to reimbursement levels are significant, we believe MA health plans have sufficient political support to avoid a repeat of the disastrous under-funding of MA that followed the Balanced Budget Act (BBA) of 1997 and led to massive plan exits from the program.

After 2006 the phase-out of "budget neutrality" will likely dampen reimbursement

Even without cutbacks, MA plan reimbursement is likely to be somewhat dampened by the scheduled 2007-2010 phase-out of “budget neutrality” on the Medicare health status risk adjustors. Authorized under the BBA of 1997, Medicare health status risk adjustors have been introduced to adjust payments to MA plans according to the health status of each MA plan’s underlying enrollment using indicators such as the prevalence of chronic diseases (e.g., diabetes). The intent is to reimburse MA plans fairly on a relative basis for underwriting risk and discourage attempts to “cherry pick” healthy members only.

As administered by the Bush Administration, budget neutrality has shielded overall MA program funding from the impact of Medicare health status risk adjustors, even as health status risk adjustors have been introduced to shift funding among the MA health plans based on the relative health status of their enrollment.

The phase-out of budget neutrality is scheduled to begin in 2007 and is projected to have a somewhat negative impact given that the approximately 6 million MA plan members are somewhat healthier on average than the 36 million that remain in traditional (government fee-for-service) Medicare programs. The precise impact on reimbursement rates is not yet known. However, recently updated analysis from CMS shows that differences between the average health status of MA and traditional Medicare populations are less than previously projected, indicating that the phase-out of budget neutrality will be less damaging to MA funding than had been feared by the industry.

Competitive bidding may lead to lower-than-expected reimbursement increases

Although we expect average MA rate increases to be in the 20% area next year, including the new drug funding reimbursement, we highlight some risk to the downside to that estimate that could result from the impact of the new “competitive bidding” process that went into effect for the first time under the program rules for 2006.

Under so-called competitive bidding, MA plans are required to pay back to the government 25% of the amount by which the statutory county-specific MA plan rate benchmark exceeds the MA plan’s “bid,” or cost projection, for providing base-level Medicare benefits. More specifically, the bid is the MA plan’s projected cost for providing the standard Medicare benefits available under traditional Medicare (i.e., the standard Part A hospital benefits and Part B physician benefits), including plan administrative costs and a reasonable profit margin (as determined by CMS).

In theory, the MA plan bid could exceed the benchmark, in which case the MA plan member would be required to pay the differential as a supplemental premium. However, in such a hypothetical case the MA plan would be inferior to traditional Medicare in terms of benefits while imposing MA plan network restrictions and would therefore not be marketable to seniors under voluntary enrollment.

In the expected situation where the bid is below the benchmark, 25% of the difference goes back to the government and the remaining 75% is available to pay for additional benefits (beyond those provided under traditional Medicare) and/or a reduction to the member-paid Part B premium. The key feature is that under competitive bidding reimbursement in 2006, only 75% of the benchmark-to-bid differential is available to fund supplemental benefits, whereas 100% of the differential was available for this purpose prior to competitive bidding. Consequently, MA plans have less funding available for a given set of added benefits than would otherwise be the case without competitive bidding.

Although details of competitive bidding have not been released, we believe it may lead to a slightly lower profit margin on MA for some companies. However, some companies participating in MA have indicated that expected savings under the additional drug plan funding will help make up the difference.

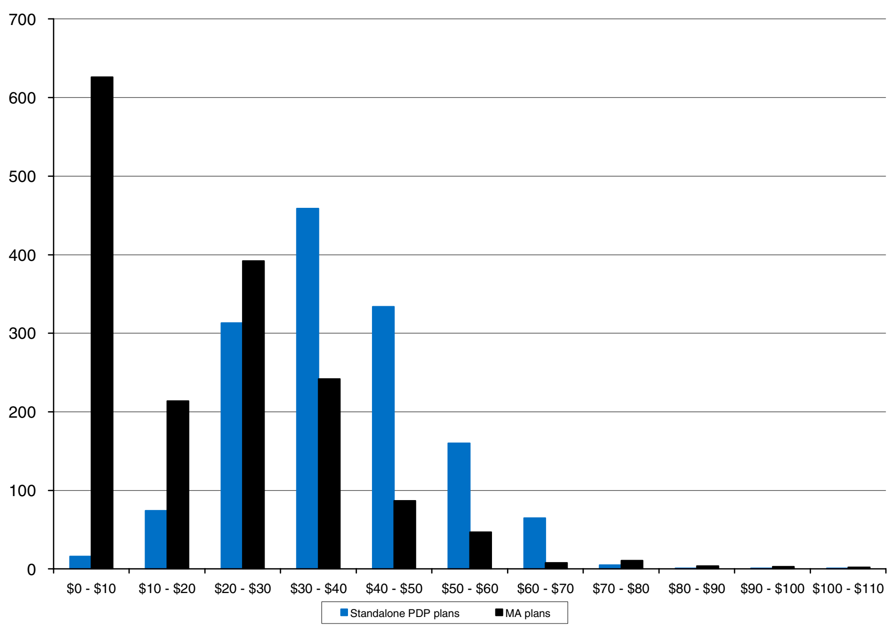
Analysis of Medicare Advantage sponsors

We analyzed the characteristics of plans by plan sponsors based on the information released by CMS. We believe the pricing is fairly competitive, with a substantial number of new market expansion by existing MA plan sponsors as well as a significant number of new entrants to the MA program.

Pricing appears fairly competitive

Based on the information released by CMS the pricing appears to be fairly competitive with one-third of MA plans offering a zero premium. The average MA premium is $19 per month, significantly lower than the average PDP premium of $37 per month. Two-thirds of drug plans offered charge premiums between $20 and $40 per month (Exhibit 42).

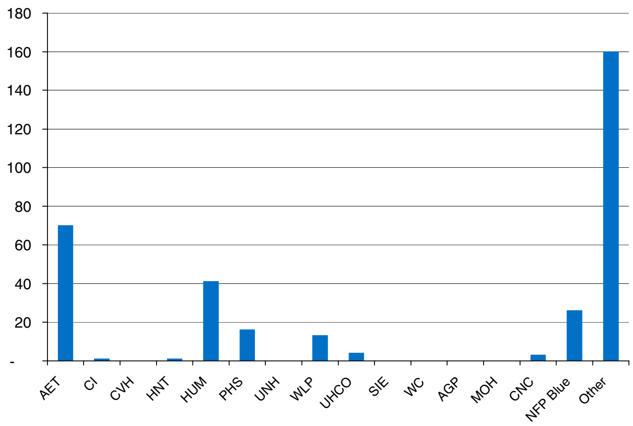
Exhibit 42: Distribution of premiums, MA versus PDP plans
Pricing lower than expected for both stand-alone PDP and MA-PDP pricing



Source: CMS and Goldman Sachs Research estimates.

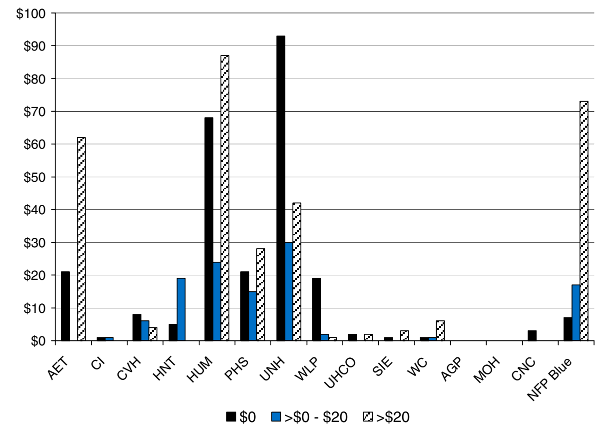
Public managed care companies account for 51% of all MA plan offerings versus 75% of stand-alone drug plans (Exhibit 43). Humana and UnitedHealth appear to offer the lowest-priced Medicare Advantage programs (Exhibit 44).

Exhibit 43: Total number of drug plans offered (all regions, all types)
Humana, United, the Blues, and non-public companies lead with the most MA plans



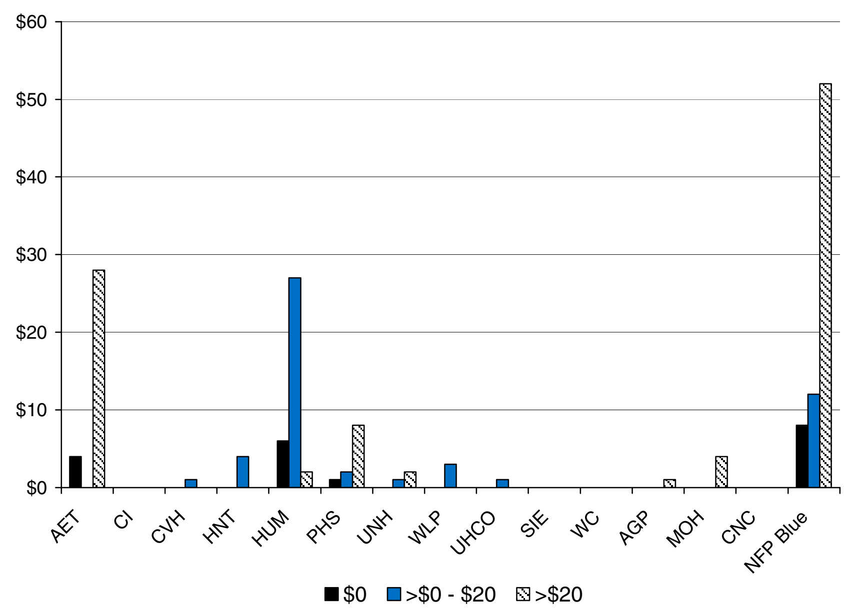
Source: CMS and Goldman Sachs Research.

Exhibit 44: Distribution of zero-deductible MA-PDP plans by company and premium level
Humana and UnitedHealth appear to offer the lowest-priced MA plans



Source: CMS and Goldman Sachs Research.

Exhibit 45: Distribution of deductible MA-PDP plans by company and premium level
As in the mid-1990s, the non-public Blues appear more cautious toward MA

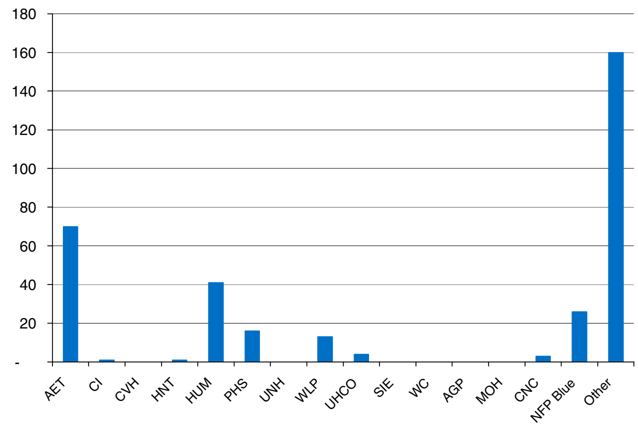


Source: CMS and Goldman Sachs Research.

MA-PDP coverage

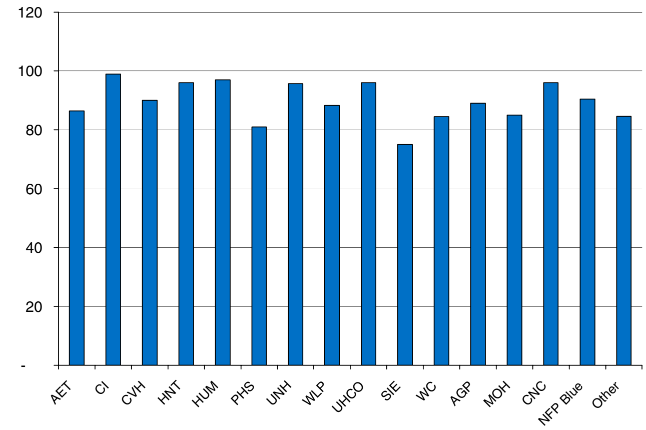
A total of 381 or 23% of Medicare Advantage plans will provide drug coverage in the doughnut hole. Approximately 80% of drug benefit in the coverage gap will be covered by generics only, while 20% of the plans will cover the doughnut hole with both generics and branded drugs (Exhibit 46). Formulary coverage is not really a differentiating factor as, on average, 88 of the top-100 drugs used by seniors will be covered (Exhibit 47). CIGNA's formulary is the least restrictive (99 top-100 drugs), while Sierra's formulary is the most restrictive (75 top-100 drugs).

Exhibit 46: Number of MA plans offered with drug doughnut hole coverage
Aetna, Humana, and non-public, non-Blue plans lead MA doughnut hole coverage



Source: CMS and Goldman Sachs Research estimates.

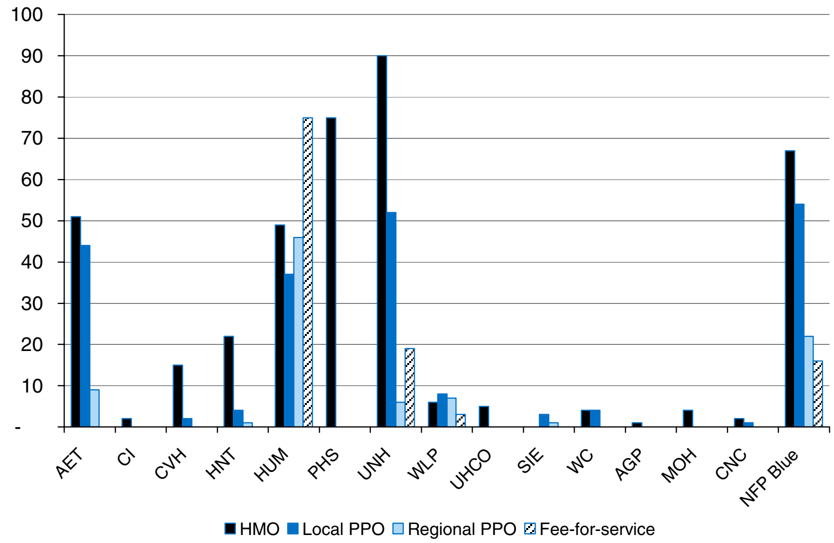
Exhibit 47: Number of top-100 drugs offered on MA plan formulary by company and premium
Sierra has the most restrictive formulary among MA plans offered



Source: CMS and Goldman Sachs Research estimates.

UnitedHealth and PacifiCare will offer the most MA HMO plans (see Exhibit 48). Other non-public, non-Blue plans will offer nearly 500 MA HMO plans or close to 50% of all MA HMO plans offered.

Exhibit 48: Number of MA plans offered by company and plan type (a)
Humana is embracing the MA regional PPO and PFFS program; others are not…



(a) 636 MA plans offered by other non-public, non-Blue companies not shown on chart to avoid skewing.

Source: CMS and Goldman Sachs Research estimates.

Potential earnings impact of Part D on managed care

In our July 13, 2005 report *Mergers and Medicare*, we brought to light the actual profit margin on Medicare Advantage MA through little-noticed regulatory disclosures. We found MA profit margin to be higher than expected at more than 6% (pretax) on average for the public companies.

We expect Medicare to represent nearly 50% of 2006 earnings growth

We believe the 2006 implementation of the Medicare Part D drug benefit will drive significant incremental earnings growth for our covered companies in two ways:

- Rapid enrollment growth and higher payment rates for MA HMO and PPO plans. We expect industry-wide Medicare HMO and PPO enrollment to expand at least 1 million (20%) in 2006, with an average increase in per-member payment rates of more than 20%, reflecting the value of the new Part D drug benefit.

- Administration of the stand-alone Part D drug benefit plans. We expect about 19 million seniors remaining in traditional fee-for-service Medicare to enroll in the new Medicare drug benefit plans.

Combining the incremental revenue and earnings growth we expect for our covered companies from the MA business and administration of PDP plans, we project Medicare-based revenues will jump 85% to $37 billion in 2006 from an estimated $20 billion in 2005, with Medicare-derived pretax earnings growing 67% in aggregate to $1.8 billion in 2006 from an estimated $1.1 billion in 2005.

We expect Medicare to drive about half of the earnings growth we project in aggregate for our covered companies in 2006, reflecting the combination of rapid earnings growth from Medicare and slower growth from core commercial products.

Exhibit 49: Medicare will drive about half of earnings growth in 2006
combined MA and PDP earnings impact for our covered companies, 2005E-2006E

			2005E		2006E				
Company	**Tkr**	**Rating**	**Pretax profit MA only ($mn)**	**Medicare % of company profit**	**Pretax profit PDP ($mn)**	**Pretax profit MA ($mn)**	**Pretax profit TOTAL ($mn)**	**Y-Y growth**	**Medicare % of company profit**
Aetna	AET	IL/N	59	3%	21	89	111	88%	5%
CIGNA	CI	IL/N	11	1%	13	14	27	150%	2%
Coventry	CVH	U/N	43	5%	14	55	69	61%	8%
Health Net	HNT	OP/N	32	7%	15	63	79	143%	14%
Humana	HUM	IL/N	329	63%	26	418	444	35%	70%
PacifiCare (a)	PHS	NR	319	57%	NA	NA	NA	NA	NA
Sierra	SIE	IL/N	19	9%	8	24	32	64%	13%
UnitedHealth	UNH	NR	202	4%	133	676	809	NMF	13%
WellChoice	WC	NR	39	8%	-	49	49	25%	9%
WellPoint	WLP	NR	74	2%	76	98	174	134%	4%
Total			**1,127**	**7%**	**305**	**1,486**	**1,792**	**67%**	**10%**

(a) PacifiCare results are aggregated with UnitedHealth assuming a merger close as of January 1, 2006.

Source: Company data, CMS, Goldman Sachs Research estimates.

Exhibit 50: We found Medicare Advantage profit margin to be above 6% on average for public companies
Medicare Advantage key statistics from state regulatory insurance reports, 2003-2Q2005

	Enrollment (000)				Medical cost ratio (MCR)				Annual only Operating cost ratio (OCR) (a)		Annual only Underwriting profit margin (b)	
	2003	2004	1Q05	2Q05	2003	2004	1Q05	2Q05	2003	2004	2003	2004
Aetna (AET)												
New Jersey	28	26	27	28	88.6%	88.6%	85.1%	91.3%	6.0%	7.3%	5.4%	4.2%
Pennsylvania	24	25	27	28	85.3%	86.7%	84.6%	93.1%	6.1%	6.1%	8.6%	7.2%
New York	18	15	14	14	87.6%	87.6%	86.9%	85.0%	6.0%	6.0%	6.4%	6.4%
California (b)	32	27	27	27	NA	NA	NA	NA	NA	NA	NA	NA
Other	4	4	5	5	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**105**	**97**	**101**	**101**	**85.2%**	**86.2%**	**85.0%**	**89.3%**	**8.0%**	**8.0%**	**6.8%**	**5.8%**
CIGNA (CI)												
Arizona	43	33	33	33	91.7%	90.3%	89.8%	92.3%	5.8%	6.0%	2.4%	3.8%
Coventry (CVH)												
Kansas	15	14	14	13	81.6%	87.7%	74.8%	68.7%	5.1%	5.2%	13.2%	7.1%
Missouri	15	17	18	18	79.2%	79.0%	81.0%	79.2%	9.0%	9.7%	11.8%	11.3%
Pennsylvania	32	33	34	35	88.9%	85.6%	87.1%	78.9%	10.4%	9.1%	0.7%	5.3%
Other	3	4	7	8	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**65**	**69**	**73**	**74**	**83.9%**	**83.3%**	**82.2%**	**78.1%**	**9.7%**	**9.4%**	**6.4%**	**7.3%**
Health Net (HNT)												
Arizona	35	32	32	31	86.4%	94.0%	88.3%	92.4%	11.7%	11.5%	1.9%	-5.5%
Connecticut	27	27	27	27	86.6%	89.8%	80.4%	89.2%	6.5%	6.8%	6.9%	3.4%
New York	6	6	6	6	94.7%	96.5%	95.7%	92.9%	7.2%	11.2%	-1.9%	-7.8%
California (b)	99	95	93	93	NA	NA	NA	NA	NA	NA	NA	NA
Other markets	0	12	13	15	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**168**	**172**	**170**	**171**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Humana (HUM)												
Kentucky / Illinois	72	72	72	72	85.1%	85.4%	93.0%	81.2%	8.9%	8.9%	6.1%	5.6%
Louisiana (acquired 4/04)	NA	34	35	36	NA	87.5%	84.7%	78.0%	NA	9.1%	NA	3.5%
Texas	21	21	22	23	79.3%	79.3%	83.9%	76.1%	10.0%	6.7%	10.7%	14.0%
CarePlus FL (acquired 2/05)	NA	NA	50	50	NA	NA	80.2%	81.7%	NA	NA	NA	NA
Florida	229	230	234	239	84.7%	81.3%	83.4%	78.9%	9.9%	9.1%	5.4%	9.6%
Other markets	6	20	37	54	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**329**	**377**	**450**	**474**	**84.4%**	**82.6%**	**84.8%**	**79.4%**	**9.6%**	**8.9%**	**5.9%**	**8.5%**
PacifiCare (PHS)												
Arizona	87	102	107	109	79.2%	83.5%	85.4%	85.5%	13.1%	11.5%	7.7%	5.0%
Colorado	53	52	53	53	79.7%	83.1%	84.3%	85.4%	9.4%	8.9%	10.9%	8.0%
Nevada	25	26	26	26	82.0%	84.7%	88.8%	85.5%	11.4%	11.5%	6.6%	3.8%
Oklahoma	18	15	15	16	75.8%	85.1%	85.7%	89.9%	12.8%	11.4%	11.3%	3.5%
Oregon	24	23	23	23	84.4%	79.8%	81.4%	83.4%	13.1%	13.3%	2.5%	7.0%
Texas	74	84	89	94	81.7%	88.9%	86.8%	89.3%	11.5%	11.0%	6.8%	0.1%
Washington	52	44	42	41	88.9%	79.8%	78.3%	79.0%	10.9%	9.7%	0.00	10.5%
California (b)	348	358	361	359	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**682**	**705**	**716**	**722**	**84.8%**	**86.1%**	**86.9%**	**87.5%**	**8.6%**	**9.0%**	**6.6%**	**4.9%**
UnitedHealth (UNH)												
Alabama	24	29	30	31	76.7%	81.8%	81.0%	91.0%	8.3%	7.9%	15.0%	10.4%
Missouri, IL and KS	57	56	55	55	83.6%	82.2%	80.3%	77.7%	11.3%	12.5%	5.1%	5.2%
Florida	46	53	55	53	82.9%	81.3%	77.8%	81.7%	12.6%	13.5%	4.5%	5.2%
North Carolina	14	20	22	25	74.2%	87.0%	77.9%	80.9%	12.5%	13.3%	13.2%	-0.3%
Mass and RI	15	15	15	17	74.9%	78.6%	76.3%	81.4%	11.3%	12.5%	13.7%	8.9%
Ohio	33	36	39	42	79.4%	83.3%	77.3%	85.5%	13.1%	12.1%	7.6%	4.6%
Oxford NY (acquired 7/04)	NA	68	68	69	NA	86.3%	87.0%	89.8%	NA	5.6%	NA	8.1%
UNH New York	10	11	11	11	NMF	81.4%	NA	NA	NMF	12.5%	NMF	6.0%
Other markets	31	42	49	52	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**230**	**330**	**345**	**355**	**80.4%**	**83.2%**	**80.7%**	**83.5%**	**11.4%**	**10.6%**	**8.2%**	**6.2%**
WellChoice (WC)												
New York	50	56	58	60	81.6%	83.9%	84.2%	82.6%	8.6%	9.4%	9.8%	6.7%
WellPoint (WLP)												
Ohio	79	80	79	78	NA	83.6%	82.9%	79.9%	NA	5.5%	NA	10.8%
Kentucky	11	10	10	10	89.0%	78.7%	89.5%	87.5%	6.1%	5.0%	4.9%	16.3%
California (b)	50	35	32	31	NA	NA	NA	NA	NA	NA	NA	NA
Other markets	12	15	21	24	NA	NA	NA	NA	NA	NA	NA	NA
Total (c)	**152**	**140**	**142**	**143**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Combined public companies (d)	**1,672**	**1,839**	**1,946**	**1,990**	**83.5%**	**84.1%**	**84.0%**	**83.8%**	**10.1%**	**9.7%**	**6.4%**	**6.2%**
Top 35 non-public companies (e)	**1,411**	**1,433**	**1,461**		**88.0%**	**89.1%**	**88.2%**	**87.9%**	**8.3%**	**6.7%**	**3.7%**	**4.1%**
Combined (public + non-public)	**3,083**	**3,272**	**3,407**	**1,990**	**86.0%**	**86.9%**	**86.3%**	**86.1%**	**9.1%**	**8.1%**	**4.9%**	**5.0%**

(a) Operating cost and underwriting profit by product line are disclosed on an annual basis only.
(b) With the exception of enrollment and revenues, product specific financial data is not provided under California regulatory reporting.
(c) Total enrollment is consistent with corporate-reported figures
(d) Represents the aggregated financial results across the public company subsidiaries with Medicare Advantage enrollment.
(e) Represents the aggregated financial results across the top 35 non-public company subsidiaries with Medicare Advantage enrollment.

Source: State insurance data, company data, Goldman Sachs Research estimates.

Rapid growth in MA could drive $450 million in new earnings in 2006

We expect at least 1 million seniors to switch to MA HMO and PPO plans in 2006 and away from traditional Medicare as the additional prescription drug funding allows managed care companies to significantly enrich benefit levels and given the number of expected service area expansions of “local” HMO and PPO plans as well as the launch of the new “regional” PPO program. The 20% growth we expect in MA HMO and PPO enrollment in 2006 is an acceleration from the 10% growth we expect in 2005. We expect the magnitude of growth to be similar to the mid-1990s, when growth in Medicare HMOs peaked before the rapid decline brought about as a result of under-funding of the program under the Balanced Budget Act of 1997.

In 2006 we expect MA HMO and PPO payment rates to increase more than 15%, to approximately $11,000 per senior per year, reflecting an MA-only rate increase of about 5% on average supplemented by the new funding that represents the actuarial equivalent value of the new Medicare prescription drug (PDP) funding.

Putting the profit margin, enrollment, and payment rate information together, we project 32% growth in MA revenues across our covered companies next year driving 32% growth in MA program-derived earnings in 2006 (Exhibit 51). We assume modest contraction in the MA profit margin reflecting a lower expected margin on the added drug funding as well as the emphasis on service area expansion and enrollment growth.

Exhibit 51: Rapid enrollment growth and higher payment rates should drive $7 billion new MA revenues in 2006
MA program enrollment, revenue, profit margin, and earnings, 2005E-2006E

			2005E				2006E				
Company	**Tkr**	**Rating**	**Lives (000)**	**Revenue ($mn)**	**Profit margin**	**Pretax profit ($mn)**	**Lives (000)**	**Revenue ($mn)**	**Profit margin**	**Pretax profit ($mn)**	**Y-Y growth**
Aetna	AET	IL/N	114	1,072	5.5%	59	164	1,684	5.3%	89	51%
CIGNA	CI	IL/N	33	268	4.0%	11	39	351	4.0%	14	31%
Coventry	CVH	U/N	79	709	6.0%	43	96	944	5.8%	55	29%
Health Net	HNT	OP/N	173	1,295	2.5%	32	205	1,712	3.7%	63	96%
Humana	HUM	IL/N	550	5,060	6.5%	329	660	6,641	6.3%	418	27%
PacifiCare (a)	PHS	NR	745	6,374	5.0%	319	NA	NA	5.0%	NA	NA
Sierra	SIE	IL/N	56	483	4.0%	19	65	600	4.0%	24	24%
UnitedHealth	UNH	NR	385	3,365	6.0%	202	1,328	12,750	5.3%	676	NMF
WellChoice	WC	NR	61	600	6.5%	39	70	749	6.5%	49	25%
WellPoint	WLP	NR	160	1,239	6.0%	74	200	1,721	5.7%	98	32%
Total			**2,356**	**20,466**	**5.5%**	**1,127**	**2,827**	**27,152**	**5.5%**	**1,486**	**32%**

(a) PacifiCare results are aggregated with UnitedHealth assuming a merger close as of January 1, 2006.

Source: CMS, company data, Goldman Sachs Research estimates.

Exhibit 52: Annualized growth in Medicare Advantage accelerating to above 10%
thousands (a)

	Jan-04	Apr-04	Jul-04	Oct-04	Jan-05	Apr-05	Jul-05	Aug-05	Sep-05
CCP	4,593	4,594	4,634	4,683	4,755	4,881	4,944	4,980	5,025
Cost	335	331	330	330	331	326	322	322	322
Demos	149	155	164	172	156	171	178	182	186
PPO demo	83	95	103	108	114	120	123	124	125
HCPPs	100	99	99	98	98	97	96	96	96
PFFS	26	32	37	44	58	88	120	135	148
PACE	9	9	10	10	10	10	11	11	11
Total	5,295	5,315	5,377	5,445	5,522	5,693	5,794	5,851	5,907
Managed care (b)	**4,702**	**4,721**	**4,774**	**4,835**	**4,927**	**5,089**	**5,187**	**5,239**	**5,298**
Other	593	594	603	610	595	604	607	612	609
Total	5,295	5,315	5,377	5,445	5,522	5,693	5,794	5,851	5,907
Annualized growth (managed care):									
T12M	**NA**	**NA**	**NA**	**NA**	**225**	**368**	**413**	**444**	**484**
T6M	NA	NA	144	228	306	508	521	517	527
Annualized growth rate (managed care):									
T12M	**NA**	**NA**	**NA**	**NA**	**4.8%**	**7.8%**	**8.7%**	**9.3%**	**10.1%**
T6M	NA	NA	3.1%	4.8%	6.4%	10.5%	10.6%	10.4%	10.5%

(a) Monthly "Medicare Managed Care Contract Report", CMS.
(b) GS definition of Medicare "managed care" includes HMO coordinated care plans (CCP), PPO demo programs, and private FFS (PFFS).

Source: CMS, Goldman Sachs Research estimates.

Administration of PDPs expected to drive $300 million in new earnings in 2006

Not including the MA members that will automatically receive the drug benefit, we expect 19.2 million seniors to enroll in a PDP in 2006, including an estimated 5.7 million low-income seniors who are dually eligible for Medicare and Medicaid and will be automatically enrolled in a PDP.

We expect our covered companies to capture more than half of this new enrollment, driving approximately $10 billion in new revenues and about $300 million in aggregate pretax earnings for our covered companies in 2006 (Exhibit 53).

Exhibit 53: We expect PDP administration to drive $10 billion in new revenues and $300 million in new earnings
projected PDP impact on our covered companies, 2006E

					Regions (max 34)		Covered lives (000)					Pretax
			Captive	Brand						Revenue	Profit	profit
Company	**Tkr**	**Rating**	**PBM**	**advtg.**	**Dual**	**All**	**Duals**	**Other**	**Total**	**($mn)**	**margin**	**($mn)**
Aetna	AET	IL/N	X		6	34	96	604	700	714	3.0%	21
CIGNA	CI	IL/N	X		6	34	57	393	450	459	2.8%	13
Coventry	CVH	U/N			12	34	197	253	450	459	3.0%	14
Health Net	HNT	OP/N	X		6	6	272	228	500	510	3.0%	15
Humana	HUM	IL/N			31	31	685	315	1,000	1,020	2.5%	26
PacifiCare (a)	PHS	NR	X		31	34	NA	NA	NA	NA	NA	NA
Sierra	SIE	IL/N			10	10	200	100	300	306	2.5%	8
UnitedHealth	UNH	NR		X	33	34	1,328	2,872	4,200	4,284	3.1%	133
WellChoice	WC	NR		X	-	-	-	-	-	-	NA	-
WellPoint	WLP	NR	X	X	34	34	698	1,702	2,400	2,448	3.1%	76
Total							**3,533**	**6,467**	**10,000**	**10,200**	**3.0%**	**305**

(a) PacifiCare results are aggregated with UnitedHealth assuming a merger close as of January 1, 2006.

Source: CMS, company data, Goldman Sachs Research estimates.

Our projections for PDP market share by company are driven by a number of factors, including the following:

- Whether the managed care company has a captive PBM that may give it a relatively stronger operating platform from which to offer a PDP.
- Whether the managed care company is making a national bid to include all 34 PDP regions or a more limited bid for selected regions (e.g., Coventry, Health Net, and WellChoice).
- Strength of the company's brand name (e.g., the Blues and UnitedHealth in conjunction with the AARP) as well as the extent of its current participation in MA programs that may give it a marketing advantage.

We project that both revenue and earnings from the PDP business will grow at least 50% in 2007, reflecting further enrollment penetration as well as the fact that the PDP enrollment deadline (late penalties are applied for seniors choosing to enroll after that date) is delayed until May 15, 2006, so that the 2006 figures do not reflect full-year revenues and earnings.

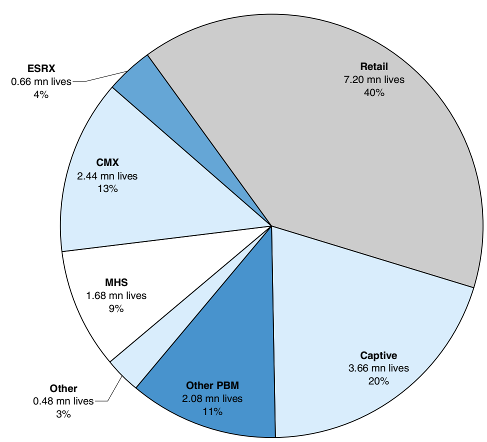
Our profit margin expectations for the PDP business, in the 2%-3% range on a pretax basis, are somewhat lower than what we believe some other Street analysts are assuming and are lower than the 4%-6% pretax margin that at least one of our covered companies, Aetna, has guided investors to expect. This reflects our view that the profit potential will be lower for the PDP business than for the MA business, given the high number of bidders for the PDP program, including managed care companies and independent PBMs as well as some retail drug chains. Partly offsetting this, we believe that our profit expectations for the MA business are slightly higher than is assumed on average by other Street analysts.

Potential earnings impact of Part D on PBMs

Based on our market share analysis, we conclude that the potential earnings impact from MMA Part D for the three largest publicly traded PBMs will most likely be minimal. A high number of competing plans will put PBMs with little consumer brand equity at a competitive disadvantage. Moreover, retail chain pharmacies (with internal PBM capabilities) have been unexpectedly successful in gaining share via partnerships with national managed care companies.

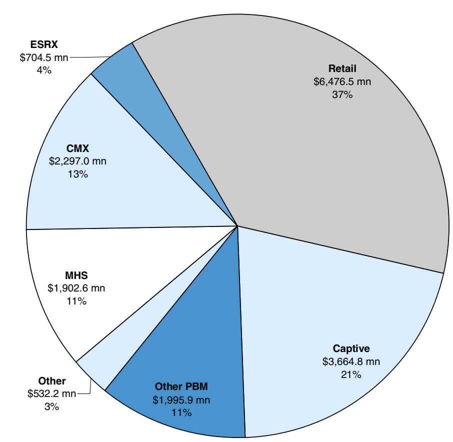
We estimate that the three big independent PBMs will only capture approximately 4.8 million lives, or 26% of the PDP population. We expect Caremark to gain the largest share with 2.4 million, or 13% of potential lives (Exhibit 54). On a revenue basis, we expect the independent PBMs to generate $4.9 billion in revenues, with Caremark realizing $2.3 billion, followed by Medco at $1.9 billion and Express Scripts at $704.5 million (Exhibit 55).

Exhibit 54: Estimated market share – lives
All Part D enrollees



Source: CMS, Goldman Sachs Research estimates.

Exhibit 55: Estimated market share – revenues
All Part D enrollees



Source: CMS, Goldman Sachs Research estimates.

Based on our assumptions for potential plan sponsor/PBM relationships and using plan premium data reported by CMS, we have estimated the potential Part D earnings impact for Caremark, Express Scripts, and Medco. In our analysis we assume that each of the participating PBMs will incur additional costs to advertise and administer the plan, either on its own or through an affiliation. Exhibit 56 summarizes some of the assumptions made in our analysis.

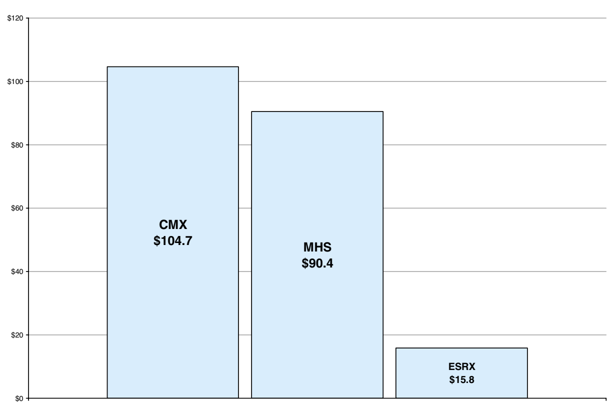
Exhibit 56: 2006 EPS impact calculation assumptions

Assumptions - All Part D enrollees	
Population	1. 5.7 million dual eligible beneficiaries (excluding Medicare Advantage enrollees) 2. 12.5 million open enrollees (excluding Medicare Advantage enrollees)
Revenue	Per member per month revenues consist of the following: 1. 47.5% of benchmark ($126.27, excluding 27% reinsurance costs) plus 2. (a) Lowest plan premium offered by a qualified sponsor in the region for dual eligibles, (b) Avg premium for each region for open enrollees.
Pretax profit margins CMX MHS ESRX	1. For plans independently managed - 5.3%. 2. For plans managed for MCO customers - 2.6%.
Plan marketing & admin. costs CMX MHS ESRX	1. For plans independently managed - $300K/region. 2. For plans managed for MCO customers - $200K/region.

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Among the three national PBMs, Caremark appears to have the largest potential Part D upside due to the highest potential participation of the big three, both through its own PDP (SiverScripts) and through support of its managed care customers. We estimate that Part D could add $0.17-$0.28 to Caremark, $0.14-$0.24 to Medco, but only $0.02-$0.05 to Express Scripts 2006 earnings. Express Scripts' participation in Part D appears to be very limited, as the company decided not to sponsor its own PDP, instead focusing on serving its managed care customers. It is unclear how much contribution each PBM expects because the companies have not provided 2006 earnings guidance.

Exhibit 57: FY2006 pretax profit impact
All Part D enrollees



Source: CMS, Goldman Sachs Research estimates.

Exhibit 58: Caremark's 2006 EPS sensitivity analysis
Likely impact in the $0.17-$0.28 range

Caremark - EPS impact sensitivity analysis

Fixed Costs per region	Pretax margin PMPM: 1.0%	2.0%	3.0%	4.0%	5.0%	6.0%	7.0%	8.0%	9.0%
50,000	$0.04	$0.09	$0.14	$0.19	$0.23	$0.28	$0.33	$0.37	$0.42
100,000	$0.04	$0.09	$0.13	**$0.18**	**$0.23**	**$0.28**	$0.32	$0.37	$0.42
150,000	$0.04	$0.08	$0.13	**$0.18**	**$0.22**	**$0.27**	$0.32	$0.37	$0.41
200,000	$0.03	$0.08	$0.13	**$0.17**	**$0.22**	**$0.27**	$0.32	$0.36	$0.41
250,000	$0.03	$0.08	$0.12	**$0.17**	**$0.22**	**$0.26**	$0.31	$0.36	$0.41
300,000	$0.03	$0.07	$0.12	**$0.17**	**$0.21**	**$0.26**	$0.31	$0.36	$0.40
350,000	$0.02	$0.07	$0.12	$0.16	$0.21	$0.26	$0.30	$0.35	$0.40
400,000	$0.02	$0.06	$0.11	$0.16	$0.21	$0.25	$0.30	$0.35	$0.40
450,000	$0.01	$0.06	$0.11	$0.16	$0.20	$0.25	$0.30	$0.34	$0.39
500,000	$0.01	$0.06	$0.10	$0.15	$0.20	$0.25	$0.29	$0.34	$0.39
550,000	$0.01	$0.05	$0.10	$0.15	$0.20	$0.24	$0.29	$0.34	$0.38

Source: CMS, Goldman Sachs Research estimates.

Exhibit 59: Medco's 2006 EPS sensitivity analysis
Likely impact in the $0.14-$0.24 range

Medco Health Solutions - EPS impact sensitivity analysis

		Pretax margin PMPM								
		1.0%	2.0%	3.0%	4.0%	5.0%	6.0%	7.0%	8.0%	9.0%
	50,000	$0.04	$0.08	$0.12	$0.16	$0.20	$0.24	$0.29	$0.33	$0.37
	100,000	$0.03	$0.08	$0.12	**$0.16**	**$0.20**	**$0.24**	$0.28	$0.32	$0.36
Fixed	150,000	$0.03	$0.07	$0.11	**$0.15**	**$0.20**	**$0.24**	$0.28	$0.32	$0.36
Costs	200,000	$0.03	$0.07	$0.11	**$0.15**	**$0.19**	**$0.23**	$0.27	$0.32	$0.36
per	250,000	$0.02	$0.06	$0.11	**$0.15**	**$0.19**	**$0.23**	$0.27	$0.31	$0.35
region	300,000	$0.02	$0.06	$0.10	**$0.14**	**$0.18**	**$0.23**	$0.27	$0.31	$0.35
	350,000	$0.02	$0.06	$0.10	$0.14	$0.18	$0.22	$0.26	$0.31	$0.35
	400,000	$0.01	$0.05	$0.09	$0.14	$0.18	$0.22	$0.26	$0.30	$0.34
	450,000	$0.01	$0.05	$0.09	$0.13	$0.17	$0.21	$0.26	$0.30	$0.34
	500,000	$0.00	$0.05	$0.09	$0.13	$0.17	$0.21	$0.25	$0.29	$0.34
	550,000	$0.00	$0.04	$0.08	$0.12	$0.17	$0.21	$0.25	$0.29	$0.33

Source: CMS, Goldman Sachs Research estimates.

Exhibit 60: Express Scripts' 2006 EPS sensitivity analysis
Likely impact in the $0.02-$0.05 range

Express Scripts - EPS impact sensitivity analysis

		Pretax margin PMPM								
		0.6%	1.1%	1.6%	2.1%	2.6%	3.1%	3.6%	4.1%	4.6%
	50,000	$0.01	$0.02	$0.02	$0.03	$0.04	$0.05	$0.05	$0.06	$0.07
	100,000	$0.01	$0.01	$0.02	**$0.03**	**$0.04**	**$0.05**	$0.05	$0.06	$0.07
Fixed	150,000	$0.01	$0.01	$0.02	**$0.03**	**$0.04**	**$0.04**	$0.05	$0.06	$0.07
Costs	200,000	$0.00	$0.01	$0.02	**$0.03**	**$0.03**	**$0.04**	$0.05	$0.06	$0.07
per	250,000	$0.00	$0.01	$0.02	**$0.03**	**$0.03**	**$0.04**	$0.05	$0.06	$0.06
region	300,000	$0.00	$0.01	$0.02	**$0.02**	**$0.03**	**$0.04**	$0.05	$0.05	$0.06
	350,000	$0.00	$0.01	$0.01	$0.02	$0.03	$0.04	$0.05	$0.05	$0.06
	400,000	$0.00	$0.01	$0.01	$0.02	$0.03	$0.04	$0.04	$0.05	$0.06
	450,000	$0.00	$0.00	$0.01	$0.02	$0.03	$0.03	$0.04	$0.05	$0.06
	500,000	-$0.01	$0.00	$0.01	$0.02	$0.03	$0.03	$0.04	$0.05	$0.06
	550,000	-$0.01	$0.00	$0.01	$0.02	$0.02	$0.03	$0.04	$0.05	$0.05

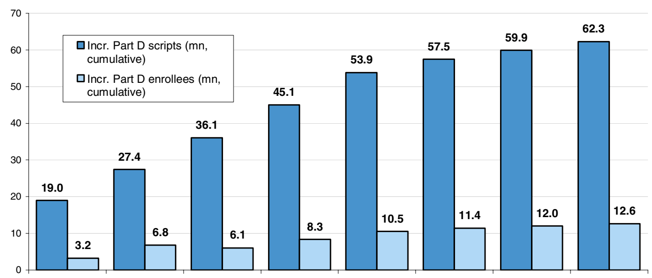
Source: CMS, Goldman Sachs Research estimates.

Earnings impact of Part D on drug distributors

Drug wholesalers have been identified as beneficiaries of the incremental pharmaceutical sales expected to be generated by the implementation of the Part D benefit. While the benefit will be expensive for the government to implement, much of that program value is a function of accounting differently for the same drug costs. We estimate incremental volume to be approximately $9.4 billion in 2006, an amount with only modest earnings implications for drug wholesalers.

We have developed a quarterly forecast for enrollment as well as estimates of the incremental purchasing power, expressed as the number of prescription drug therapies being consumed annually (see Exhibit 61). The focus on the supply chain is to estimate the incremental sales volume in the US pharmaceutical channel. Given a modest enrollment rate forecast in the open enrollment period, we forecast only $9.4 billion in new pharmaceutical sales in 2006 (and $13.0 billion through 2007).

Exhibit 61: Quarterly forecast of Part D incremental benefits



Cumulative PDP and MA enrollees by quarter (mn)	Mar 06E	Jun 06E	Sep 06E	Dec 06E	Mar 07E	Jun 07E	Sep 07E	Dec 07E
TOTAL - PDP & MA enrollees	17.4	20.9	23.5	25.7	28.1	29.1	29.8	30.4
TOTAL - Incremental PDP & MA enrollees	3.2	6.8	6.1	8.3	10.5	11.4	12.0	12.6
TOTAL - Incremental scripts	19.0	27.4	36.1	45.1	53.9	57.5	59.9	62.3
Average $/Rx	$69.65	$69.65	$69.65	$69.65	$69.65	$69.65	$69.65	$69.65
Incremental quarterly sales ($, mn)	$3,964.4	$1,769.9	$1,806.5	$1,879.1	$1,840.7	$755.8	$503.8	$503.8
Cumulative incremental sales ($, mn)	$3,964.4	$5,734.3	$7,540.9	$9,419.9	$11,260.6	$12,016.4	$12,520.2	$13,024.1
MCK incremental sales ($, mn)	$1,506.5	$672.6	$686.5	$714.0	$699.5	$287.2	$191.5	$191.5
CAH incremental sales ($, mn)	1,149.7	513.3	523.9	544.9	533.8	219.2	146.1	146.1
ABC incremental sales ($, mn)	991.1	442.5	451.6	469.8	460.2	188.9	126.0	126.0
	Mar 06E	Jun 06E	Sep 06E	Dec 06E	Mar 07E	Jun 07E	Sep 07E	Dec 07E
Estimated MCK EPS impact (quarterly)	$0.08	$0.03	$0.03	$0.03	$0.03	$0.01	$0.01	$0.01
Estimated CAH EPS impact (quarterly)	$0.03	$0.01	$0.01	$0.02	$0.02	$0.01	$0.00	$0.00
Estimated ABC EPS impact (quarterly)	$0.08	$0.03	$0.03	$0.04	$0.04	$0.02	$0.01	$0.01
	F 2006E				F 2007E			
Estimated MCK EPS impact (fiscal year)	$0.08				$0.12			
		F 2006E				F 2007E		
Estimated CAH EPS impact (fiscal year)		$0.05				$0.05		
			F 2006E				F 2007E	
Estimated ABC EPS impact (fiscal year)			$0.15				$0.10	

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Extrapolating this market view onto the drug wholesaling segment, we estimate the EPS impact for the three largest drug wholesalers – AmerisourceBergen (U/N), Cardinal Health (OP/N), and McKesson (IL/N). Our model assumes an incremental operating margin above our quarterly operating margin forecast, a constant mix of generics (versus branded), and volume distributed on the basis of national market share. We estimate that the range of earnings impact is $0.04 (Cardinal) to $0.13 (AmerisourceBergen) in 2006.

So many plans, how is a senior to chose?

One of the biggest takeaways from the data released by CMS is that there are a significant number of plans and plan sponsors and they vary significantly in pricing and coverage options. We believe the complexity of options will impede the selection process as seniors are overwhelmed by the number options.

Senior "tool kit" to help plan selection

We analyzed the CMS tools available to seniors to identify which stand-alone drug plans are likely to initially attract seniors' attention. Seniors will likely be confused given the number of plan offerings, the limited number of tools currently available, and the complexity of choices. As a result we believe most seniors will use simple metrics to compare plans – brand recognition, premium pricing, coverage and deductibles, and the number of needed drugs covered on the plan formulary.

CMS currently offers "cost estimator" and "plan offering by state" tools. The cost estimator indicates whether an individual would save money under the new drug coverage but is not useful in selecting a specific plan. The plan offering by state tool is helpful in terms of steering seniors toward the lowest-priced plan but does not appear to be user-friendly for seniors in terms of comparing non-price features of different plans (e.g., coverage in the doughnut hole).

CMS is expected to launch its "prescription drug finder" tool on its website in the near future. The plans most likely to be recommended based on drug searches using this tool are those with the most comprehensive formularies, including CIGNA, Humana, and Coventry (Exhibit 62).

Exhibit 62: Prescription drug plan characteristics comparison

Rank	Brand advantage	Richness of formulary (b)	Lowest premium plans (c)
1	UnitedHealth (a)	CIGNA	Humana
2	WellPoint	Humana	Coventry
3	WellChoice	Coventry	WellPoint
4	Aetna	UnitedHealth	WellCare
5	CIGNA	Health Net	Other

(a) UnitedHealth with the AARP endorsement
(b) Richness indicates a plan has more drugs on the top 100 drug list, analyzed region by region
(c) Lowest price plans, analyzed region by region

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Exhibit 63 illustrates the wide range of premiums and benefits in four of the largest states with high senior populations (California, Florida, New York, and Texas). In general, most of the lowest premiums include the standard premium. The highest premiums often offer a zero deductible but not always. Coverage in the doughnut hole tends to be an attribute of higher-premium plans but not consistently across the plans.

Exhibit 63: Attributes of highest- and lowest-premium plans in select regions

PDP Region	State	Sponsor	Premium	Drug Deductible			Tiered copay for drugs	Type of addl coverage in Coverage Gap		Mail order offered	Average number of top 100 drugs on formulary
				Zero	Reduced	Standard		Generics only	Generics and brands		
32	CA	Humana	$5.41			x				x	97.0
32	CA	UHCO	$66.08	x			x			x	96.0
11	FL	Humana	$10.35			x				x	97.0
11	FL	Universal Health	$104.89	x			x		x	x	76.0
3	NY	Humana	$4.10			x				x	97.0
3	NY	HealthNow	$85.02			x				x	88.0
22	TX	Humana	$10.31			x				x	97.0
22	TX	UHCO	$68.41	x			x			x	96.0
PERCENTAGE OF TOTAL			-	29%	0.0%	71.4%	28.6%	0.0%	14.3%	100.0%	-
AVERAGE			$40.88	-	-	-	-	-	-	-	92.6

Source: Centers for Medicare and Medicaid Services, Goldman Sachs Research estimates.

Risk to Medicare Part D outlook

Increased competition may drive down profit margin

- PDP – high number of potential bidders for 2006
- PDP – massive enrollment stakes may drive a "land grab"
- MA – low barriers to entry, business less scale driven than commercial
- MA – provider groups entering as competing plans (PSOs)

Political risks to reimbursement

- Higher managed care profit increases risk of "takeback"
- Fiscal pressures on Medicare make profit a target
- Lack of political consensus on Medicare managed care
- Next catalysts: lead up to 2006 mid-term elections and 2008 US Presidential election

Potential to fall short of expectations

- Take-up of MA and/or PDP plans by seniors may be less than expected
- Profit margin may be disappointing, particularly for PDP business
- Medicare part A/B claims administration: a low-margin business now shunned by most for-profit managed care companies

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