EQUITY

RESEARCH:

UNITED STATES

Managed Care

June 8, 2006

Charles Boorady
212-816-7539
charles.boorady@citigroup.com

Laura A. Hubbard
212-816-5701

Sara C. Moreno
212-816-0285

Medicare-Industrial Complex

Managed Care and the Health Care Cold War

- The government today spends as much on health care as all of corporate America earns each year. High Medicare spending is accelerating given new technology and an aging population. Spending akin to the military's infamous $659 ashtray and $3,000 coffeemaker is going toward medical products. Physician error, much of it via care paid for by Medicare, is a leading cause of death.
- Medicare Advantage weans Congress off the iron triangle of this Medicare-Industrial complex. The $400 million per year in campaign contributions and lobbying by the health care industry should not stop the move to a defined contribution system that relies on market forces, and can be more easily budgeted and means-tested.
- Wall Street is skeptical that Congress will let private Medicare Advantage plans win this health care cold war and lure remaining seniors out of government-run plans. Consensus stock ratings are more bullish on commercial plans than Medicare plans.
- We have the opposite view and recommend purchasing HUM, UNH, WLP, CVH, and HNT. We see a handoff to Medicare elongating the cycle of double-digit profit growth. Unlike the last cycle when both Medicare and commercial fell, today, Medicare is expanding while commercial is slowing, not contracting.

United States

Table of Contents

[redacted]

We present our contrarian view that is bullish on the long-term prospects for Medicare Advantage. We believe the iron triangle of the Medicare-Industrial-Congressional complex must be broken to address inefficiencies in the health care system that becomes less affordable due to our country's deficits and the aging of baby boomers. We believe a handoff to accelerating Medicare plan growth from decelerating commercial growth will elongate the profit cycle for managed care by driving new customer growth and increasing leverage over the providers of health care services and manufacturers of health care products. This is different from the last cycle in which both commercial and Medicare declined together.

In this report we present our case for investment.
Managed care organizations offer Medicare Advantage (MA) plans as vehicles to provide seniors in Medicare with better health care options that waste fewer tax dollars. We also present a history of Medicare and how it works. And we respond to commonly asked questions and concerns raised.

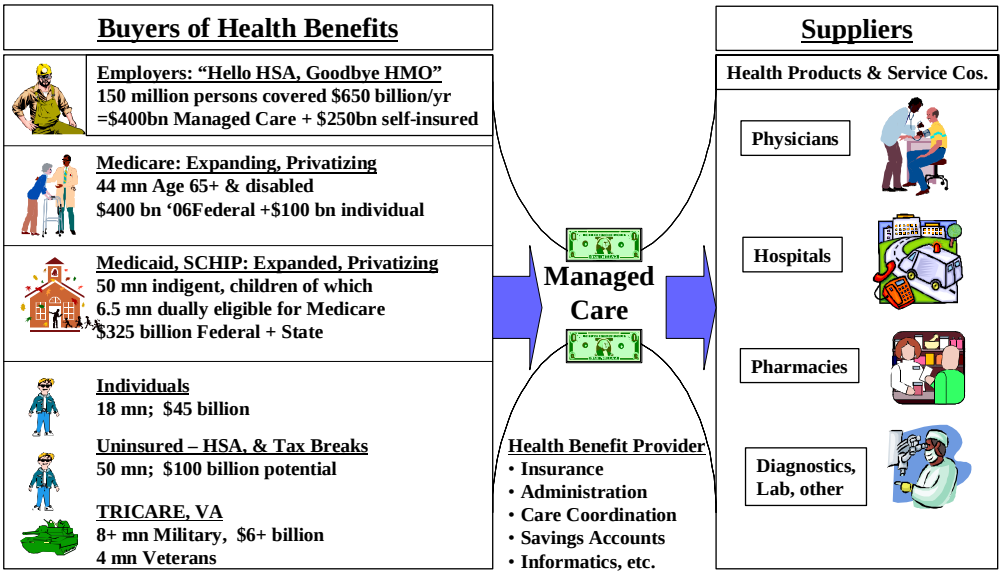
We believe Medicare Advantage plans will thrive.
Some see investing in Medicare as a "trade" that is over with the January 2006 launch of Part D. We believe it is just getting going. The revenue and profit opportunity for managed care from Medicare Advantage has the potential to exceed that of the commercial business. We believe MA will not only survive the next presidential administration but will also thrive as the only proven way to control spiraling Medicare costs. We believe MA will break the iron triangle driving up health spending in the U.S. by pulling Congress out of the business of running a health insurance business and into the financing of private insurance.

EPS growth should be faster for companies in Medicare.
We estimate three-year earnings CAGR of 16%–22% at companies, like Humana and UnitedHealth Group, that have a large investment in Medicare, and a much slower 8%–12% CAGR for pure-play commercial health plans, such as Aetna and CIGNA, that do not have meaningful exposure to Medicare. Commercial revenue growth is slowing in part due to the move to high-deductible health plans, while commercial profit margins are at or near peak levels.

EPS growth will drive stocks higher.
The bear case for the managed care industry is that EPS growth is slowing. However, we model average EPS for managed care organizations will grow two times faster than that of the S&P 500 in 2006–09, whereas we estimate managed care stocks will track at a discount P/E to the S&P 500.

Medicare: An Important New Growth Driver

Figure 1. Health Care Intermediaries



Source: Company reports and Citigroup Investment Research

Each End Market on a Different Cycle

Commercial Elongated Cycle and Soft Landing

- Employers spend more than $650 billion per year providing health coverage to 150 million people. Of that, about $400 billion are revenues to managed care while $250 billion is spent by self-insured employers on health care expenses that are not captured by managed care. Wall Street's focus is mainly on the commercial business where most profits are earned by public companies today.
- See our June 28, 2006 "Hello HSA, Goodbye HMO" report (order no. US06M131) and slides in the appendix of this report for our view on the elongated commercial cycle and soft landing, including our projection for premium growth decelerate to 2% by 2010.

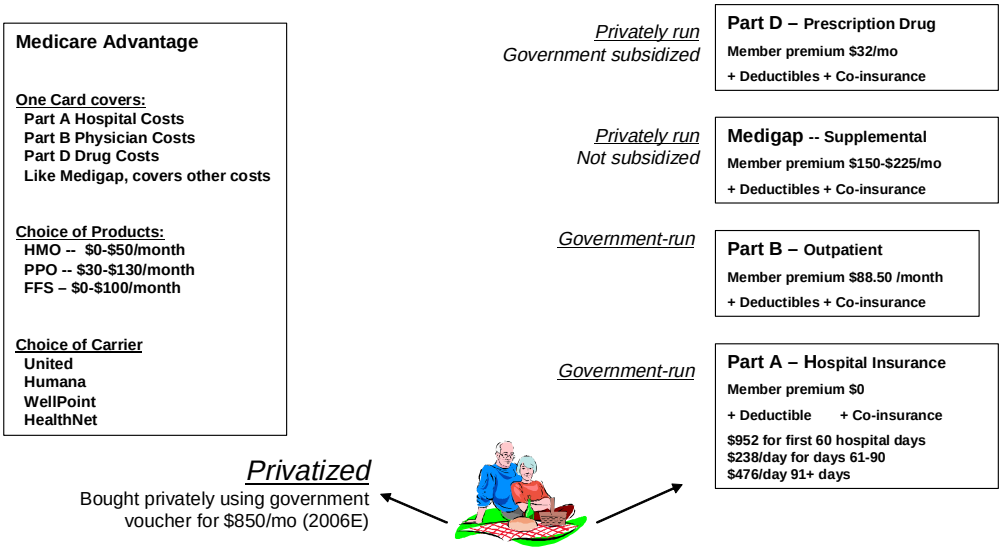
Medicare and Medicaid Are Expanding and Privatizing

- The roughly 44 million seniors age 65+ consume more than $500 billion in health care services and products annually, of which more than $400 billion is paid for by the federal Medicare and federal-state Medicaid programs.

Medicaid is a $325 billion annual program providing health benefits to the indigent and children of uninsured. States are encouraging this population to move into managed care plans as a way to control spending growth.

Each Senior Can Choose Private or Government-Run Insurance

Figure 2. Medicare Customer Decision Tree



44mn Age 65+ & Disabled, 11mn get low income aid
$500bn /yr = $400bn '06 Federal +$100bn Individual

Source: Citigroup Investment Research

Why Do Seniors Join Medicare Advantage?

- It is voluntary and they like it.
- Seniors receive better coverage, valued at about $100 per month.
- Employers find it to be a more efficient way to manage retiree health benefits.
- Ease of use: One card covers all expenses, and there is only one company.

Why Should the Government Allow Citizens to Choose Between Private and Government-Run Insurance? We Offer Three Different Perspectives:

- **The Ideologue and Policy Wonk:** Should the U.S. federal government run a health benefit company? Is Congress qualified to make decisions on medical coverage? Can we control against the iron triangle of the Medicare-Industrial-Congressional complex in which lobby dollars and campaign contributions are rewarded with overpayments to industry?
- **The Economic Realist:** Which maximizes the utility of tax dollars? Which provides taxpayers with the best value? What is the opportunity cost of time Congress spends running health insurance versus addressing other issues facing our country like energy needs and national defense?
- **Budget Think:** Which is "cheaper?" Theory: Socialism is "cheaper" because one government with central control can more efficiently run a health insurance company than the many private ones, just as the federal governments of Russia

and China could make cars, shoes, and other things more cheaply than a free enterprise of private industry. Reality: See China today.

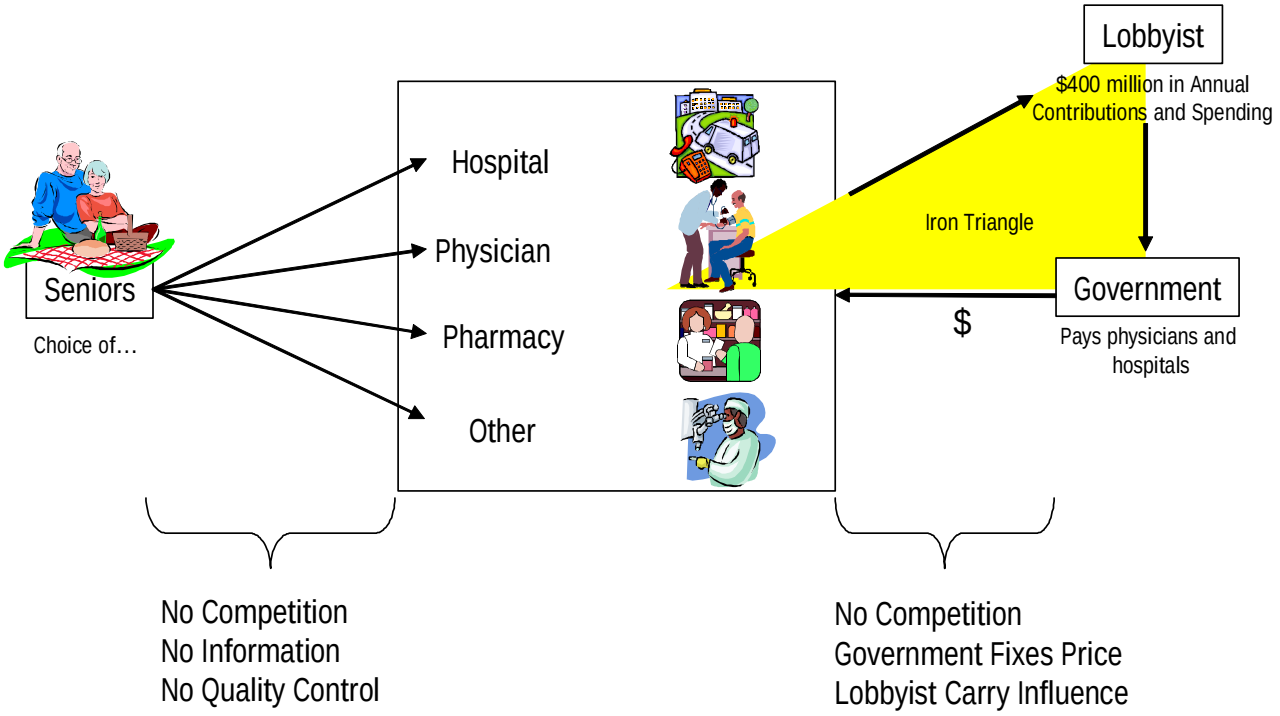
Are There Other Precedents on Privatization?

- **Medicaid:** The best precedent for Medicare is that states have been moving the indigent into privately run Medicaid managed care plans, mostly HMO (health maintenance organization) products, that demonstrate improved quality of care at a lower price.
- **Food Stamps:** A good precedent: The federal government gives vouchers to buy groceries at privately run grocery stores.
- **Schools:** Bad precedent but a good lesson: School vouchers are more controversial as many liberals are concerned about the ability to shape the education moving away from religious or other teaching institutions. Also, from an economic standpoint, privatizing schools is more difficult to justify since education costs are largely fixed whereas health insurance costs are largely variable.

How Much Influence Does the Industry Have?

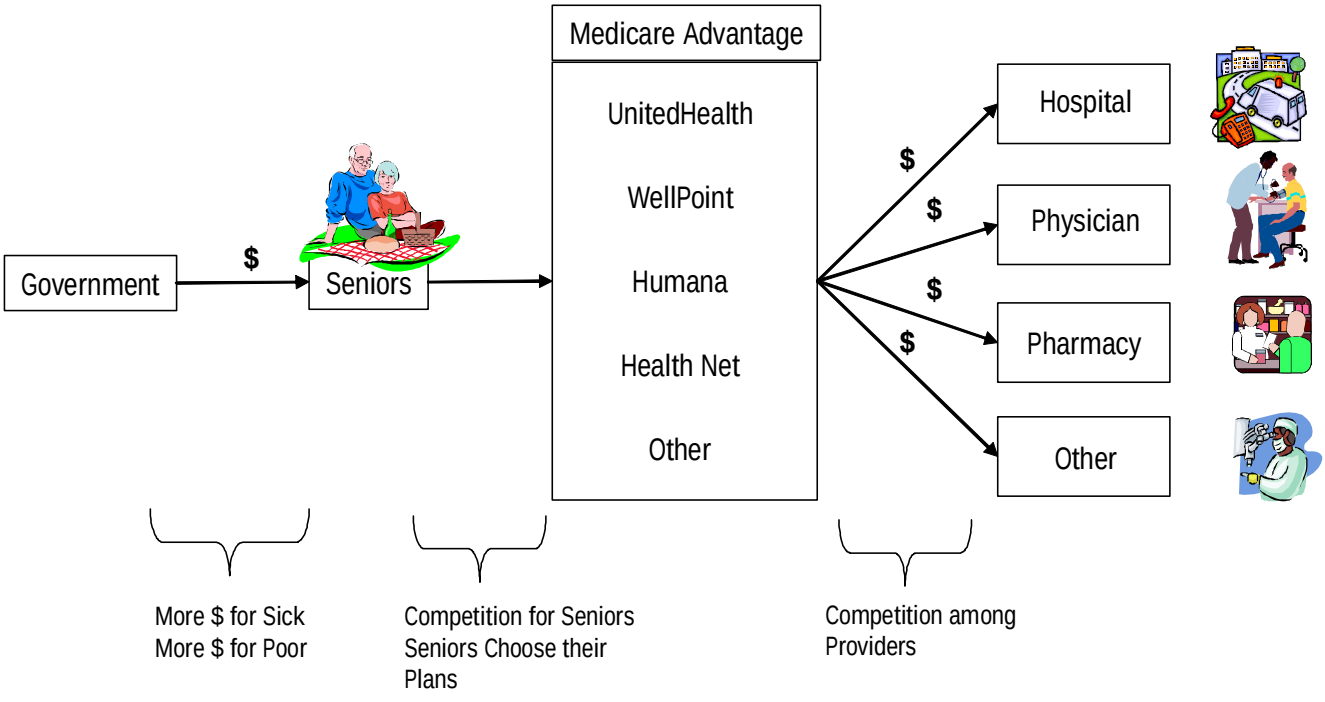
Figure 3 depicts the iron triangle of the Medicare-Industrial-Congressional complex, including the overpayments by Medicare to providers of healthcare products and services. This system is broken, in our view, for taxpayers and seniors who receive inconsistent care. The system is analogous to the one that procured military equipment that included a $659 ashtray and a $3,000 coffeemaker. Figure 4 shows how Medicare Advantage, a system of defined contribution, weans Congress off lobby dollars from health care companies and introduces more competition. The amount spent by health care companies to lobby Congress and contribute to election campaign continues to grow (see Figures 5–7).

Figure 3. Current Defined Benefit System



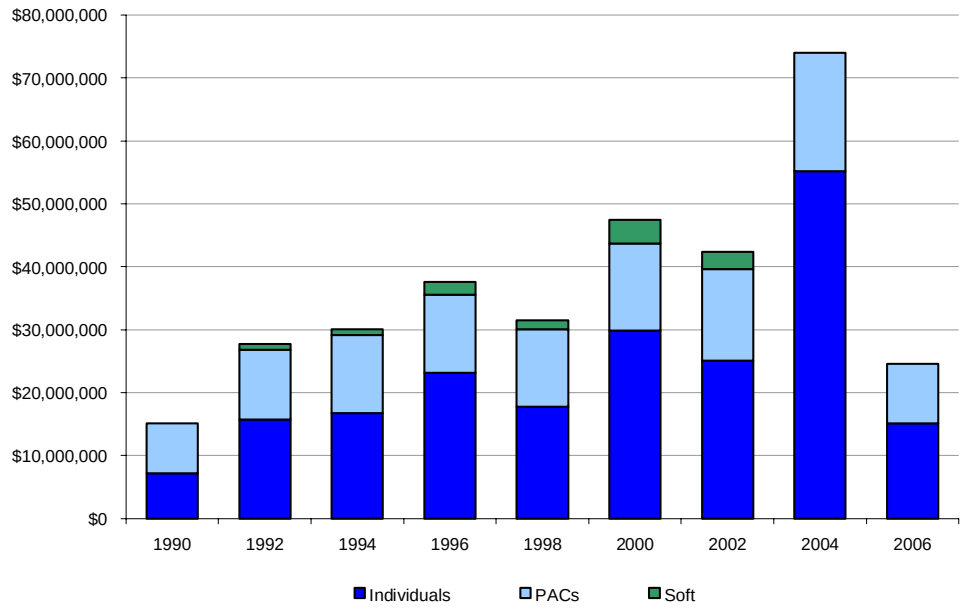
Source: Citigroup Investment Research

Figure 4. Defined Contribution "Medicare Advantage"



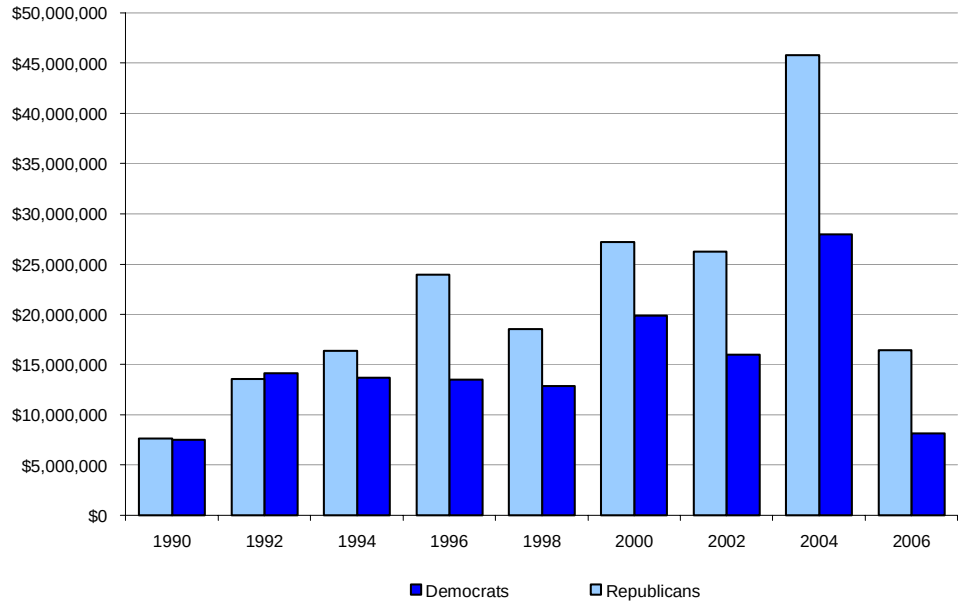
Source: Citigroup Investment Research

Figure 5. Contributions to Federal Candidates from PACs (Political Action Committees) and Individuals



Source: Center for Responsive Politics

Figure 6. Contributions to Federal Candidates to Democrats and Republicans



Methodology: The numbers in Figures 5 and 6 are based on contributions of $200 or more from PACs and individuals to federal candidates and from PAC, soft money, and individual donors to political parties, as reported to the Federal Election Commission. While election cycles are shown in Figures 5 and 6 as 1996, 1998, 2000, etc., they actually represent two-year periods. For example, the 2002 election cycle runs from January 1, 2001 to December 31, 2002. Data for the current election cycle were released by the Federal Election Commission on Monday, April 24, 2006.

Source: Center for Responsive Politics

Figure 7. Health Care Industry Spends More than $300 Million per Year Lobbying

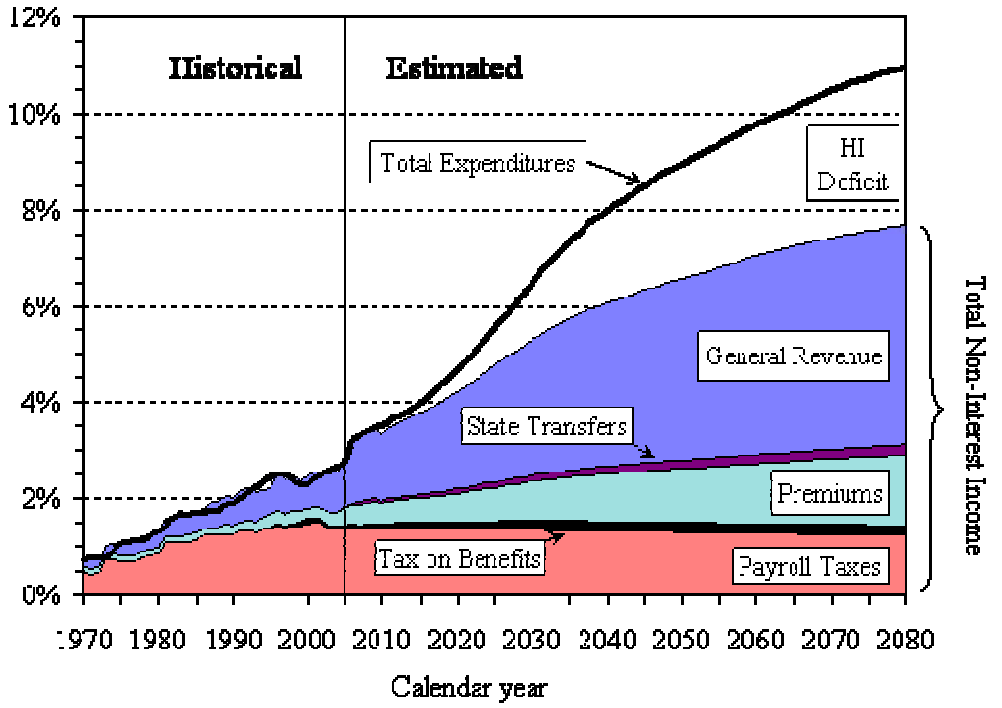
	2000		2003
Drug	$96		$109
Physician	$46	}	> $160
Hospital & Nursing	$40		
Health Insurance	$31		$31
Total	**$213**		**> $300**

Source: Center for Responsive Politics

Is Managed Care Needed and What's Wrong with Status Quo?

- The current system is on an unsustainable path that needs to change.
- Many see Medicare Advantage as an experiment that will be undone in a future presidential administration.
- We have the opposite perspective. We believe one look at the future growth projections could change the opinion of those who believe Medicare should remain a defined benefit plan run by the government. That program is on what appears to be an unsustainable path today.
- Medicare costs are projected to grow substantially faster than the economy over the next several decades. However, tax income to the HI Trust Fund is not. Of course, we can always raise taxes and adjust the eligibility age to offset and postpone the fiscal pain. But the point remains that the cost of Medicare is putting on our economy a deadweight burden that is growing at a troubling rate. Increasing the eligibility age would leave millions uninsured since fewer and fewer employers offer retiree health benefits. So that move would not solve a problem but, rather, create other political problems. For example, do those uninsured wind up in Medicaid?
- The primary source of funding for HI is the payroll tax, which is not scheduled to change, and income from the other tax sources to these programs will rise only gradually as a greater proportion of beneficiaries become subject to taxation in future years.
- The mounting financial shortfall in these programs is illustrated in Figure 8. It shows that as a percentage of GDP, the gap between annual total expenditures and total noninterest income increases over time.

Figure 8. Medicare Expenditures and Noninterest Income by Source as a Percentage of GDP

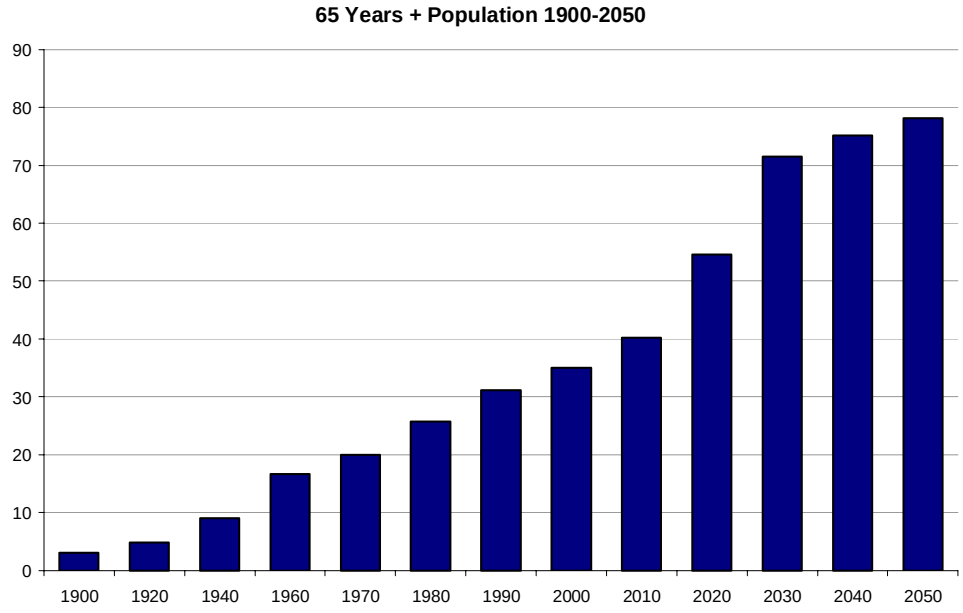


Source: Medicare Trustees Report, 2006

- The elderly population, defined as those 65 years old or older, has grown rapidly in the last century. From 1990 to 1960, the number of elderly increased tenfold, while the population under age 65 increased by only 2.2 times. Moreover, between 1960 and 1990, the number of elderly grew by 88%, compared with 34% for the number of those under age 65.
- During 1990–2010, the elderly growth rate will be lower than during any 20-year period since 1910 due to the low fertility rate of the 1930s. After this, there will be an elderly population explosion between 2010 and 2030 as the baby boomer generation reaches age 65.
- The elderly population is expected to climb after 2010 and peak around 2035 as the baby boomers retire and the traditional working age declines.

Figure 9. The Aging of the Population Will Increase the Demands on Medicare

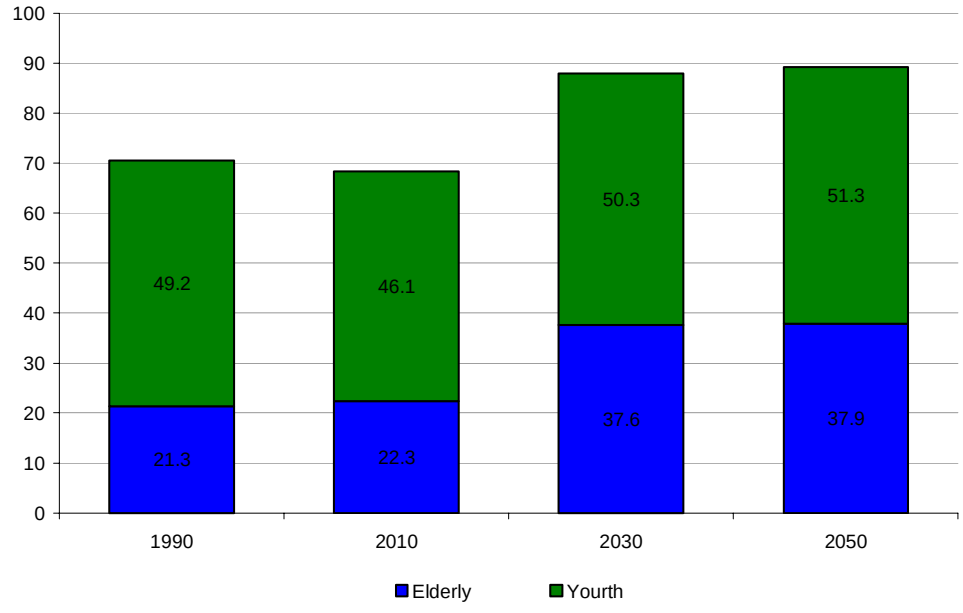
$ in millions, except per share data



Source: U.S. Bureau of the Census

Figure 10. Ratio of Elderly to Working-Age Population to Nearly Double from 1990 to 2050

$ in millions, except per share data



Source: U.S. Bureau of the Census

Are Medicare Advantage Plans Overpaid Today?

➤ Health plans are intermediaries in a largely variable cost and highly competitive business. So, to say they are overpaid is really saying we are providing seniors

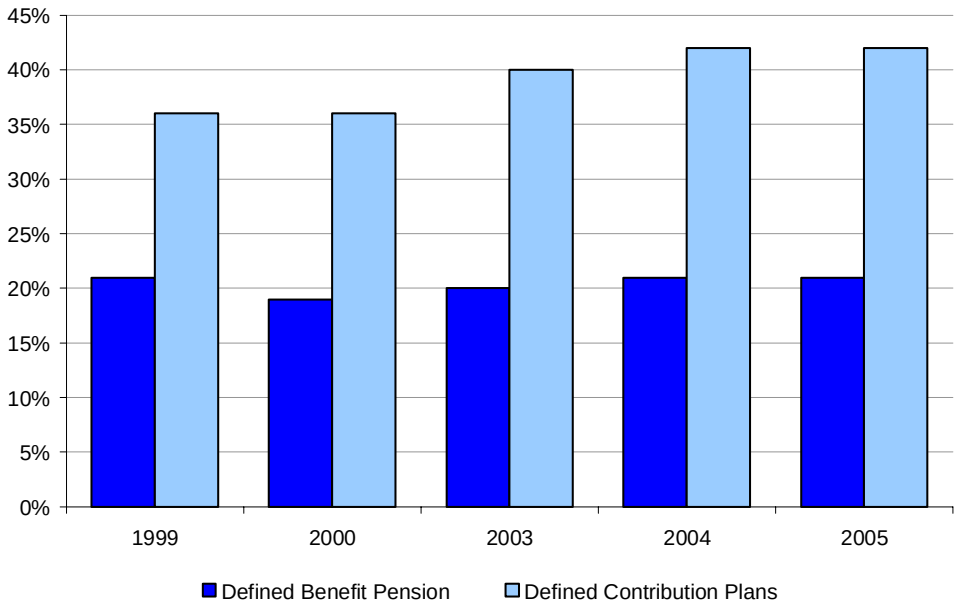
with too much health insurance. Health plans will keep a certain spread and pass through any additional revenues to seniors in the form of greater benefits. If reimbursement is cut they will pass the portion left uncovered through to seniors. Cutting payments to managed care will cut benefits to seniors.

- Taxpayers are spending more on Medicare Advantage per capita than on government-run Medicare, but, as we see it, less money is wasted, allowing the difference to benefit seniors. Put differently, we believe seniors are getting a "bonus" of about $100 per month in additional benefits by enrolling in a Medicare Advantage plan.
- While the main concern of many taxpayers is to pay as little as possible, it is important for our economy to waste as little as possible. Long term, that means getting as many seniors into Medicare Advantage plans as possible. Medicare Advantage saves money by negotiating lower unit prices in exchange for steering volume, whereas the "iron triangle" often over pays.
- Medicare Advantage saves money: Medicare's actuaries said that data show that HMOs serving Medicare beneficiaries provide benefits at about 5% below the average cost of caring for Medicare beneficiaries in the traditional government-run Medicare fee-for-service program. So far, regional preferred-provider organizations, which are health plans with far fewer controls over patient choice of physicians or access to care, have not provided care at a lower cost than traditional Medicare, the actuaries said.
- Near term, we do not think the government will kill the Medicare Advantage geese that are laying the golden eggs of privatization.
- Longer term, as penetration of managed care grows, we believe the government can achieve additional savings by simply means-testing the subsidy. Means-testing is anathema to socialists, but it is already happening to some extent with Part B, and the same goal is being achieved differently in Part D through a low-income subsidy. High health costs drive many seniors literally into the poorhouse, i.e., long-term care paid for by Medicaid, the current system of Medicare, and dual-eligible Medicaid does drive a wedge between the wealthy and the poor, creating two classes of seniors. So means-testing ultimately may actually appeal to socialists and compassionate conservatives more than this current expensive and socially unfair system.

Is This a New "Fad" That Will Go Away with the Next President or Congress?

- One of the biggest concerns on Medicare Advantage we hear from investors is that it is a new program that originated with the current presidential administration, and it will be wiped out with the next administration.
- The move to defined contribution from defined benefit for Medicare dates back to 1985. Also, employers have begun moving to defined contribution. Moreover, most of the rest of the Western world is moving away from central government control toward more free enterprise in health care and other industries.

Figure 11. Employers Also Moving to Defined Contribution (Percent of Workers in Type of Plan)



Source: Bureau of Labor Statistics

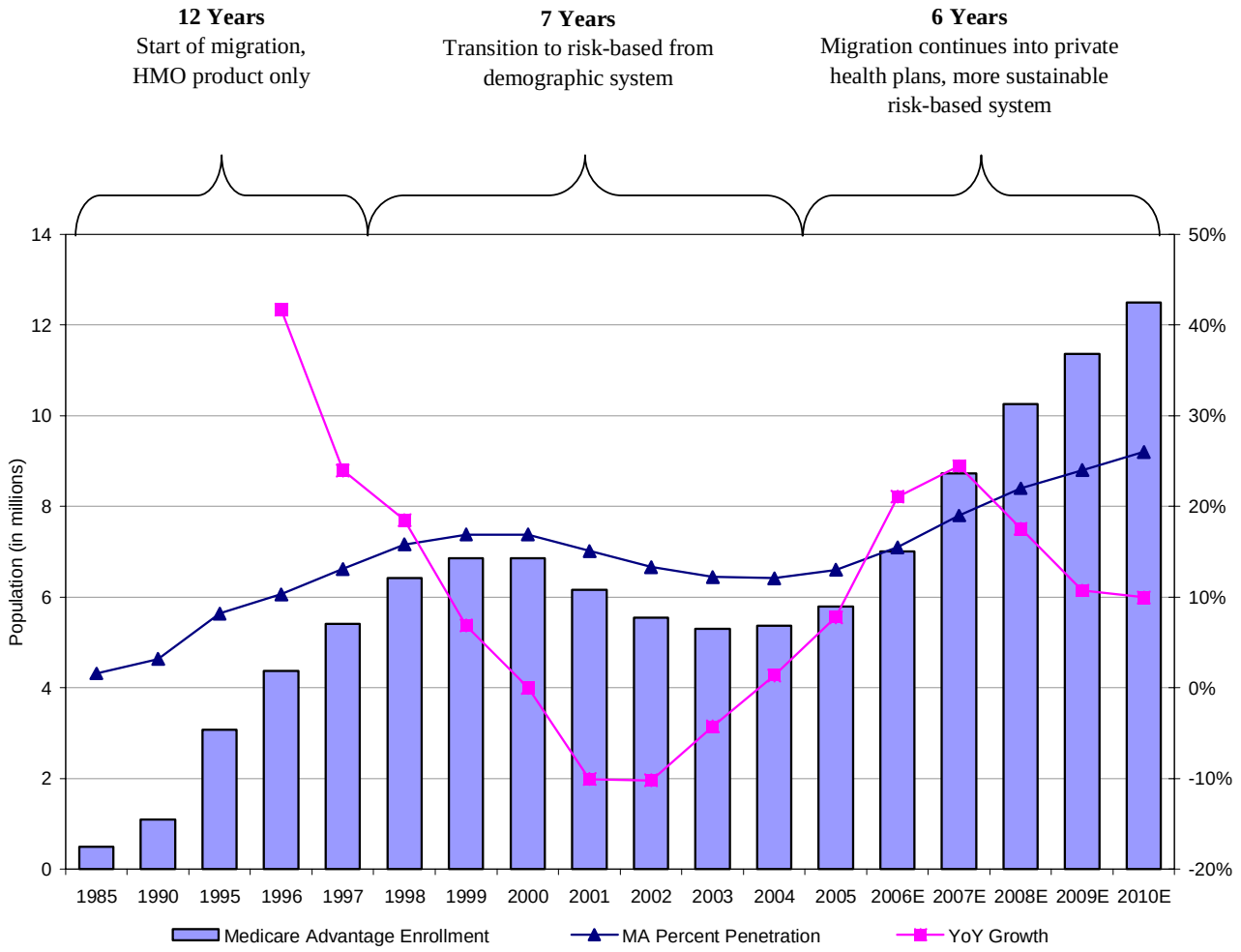
- What we now call Medicare Advantage is actually the grandchild of a program that began in 1985 with just an HMO option, which gave birth to Medicare+Choice in 1997, which gave birth to Medicare Advantage in the Medicare Modernization Act of 2003. Penetration reached a peak of about 16% in 1998, about where it is today, before falling to a low of about 11.5% in mid-2004.

Are Investors Fighting the Last War by Shunning Medicare?

- The Balanced Budget Act of 1997 called for a change that would make the program more viable by moving to a risk-based payment system from a demographic-based system to mitigate "cherry picking" of healthy seniors by health plans. The transition over the following six to seven years resulted in some health plans pulling out of the business if they could not find a way to survive under the new payment method.
- The drop in enrollment from 1999 to mid 2004 reflected plans leaving the business and not seniors leaving the plan; we believe seniors like the product.
- Now that risk-based scheme is almost fully implemented, the business is growing again — we think indefinitely.
- The Medicare Modernization Act of 2003 is adding a new subsidy for prescription drugs that gives health plans a good foot in the door to up-sell hospital and physician insurance (Medicare Advantage) to seniors.
- Also, new products beyond the HMO now exist such as a PPO (preferred provider organization) and fee-for-service option. These non-HMO products will appeal to the wealthier senior who can now afford supplemental "Medigap" insurance or who is covered by an employer-sponsored retiree plan.

➤ We expect employers to increasingly offer retirees the option of a Medicare Advantage plan as a way to ease retiree benefit expense burdens.

Figure 12. We Estimate More than 25% of Seniors Will Enroll in Medicare Advantage by 2010



Source: Company reports and Citigroup Investment Research

Who Loses from Breaking the Iron Triangle? Isn't It a Zero-Sum Game?

➤ To identify the "losers" in the move to Medicare Advantage, it is important to identify who benefits from the inefficiencies of today's "iron triangle" of the "Medicare-Industrial-Congressional" complex. In other words, who is being overpaid by Medicare?

➤ Medicare overpays in two ways: Unit prices are too high and volumes are too high.

➤ **Unit Prices:** By fixing prices at an artificial rate, the government does not take advantage of using a market-based system to trade higher volume for lower unit prices. Also, because of how it pays hospitals for certain procedures, there is little to no competition for the purchase of knees, hips, and other expensive devices. Therefore, we believe many manufacturers of drugs and devices that

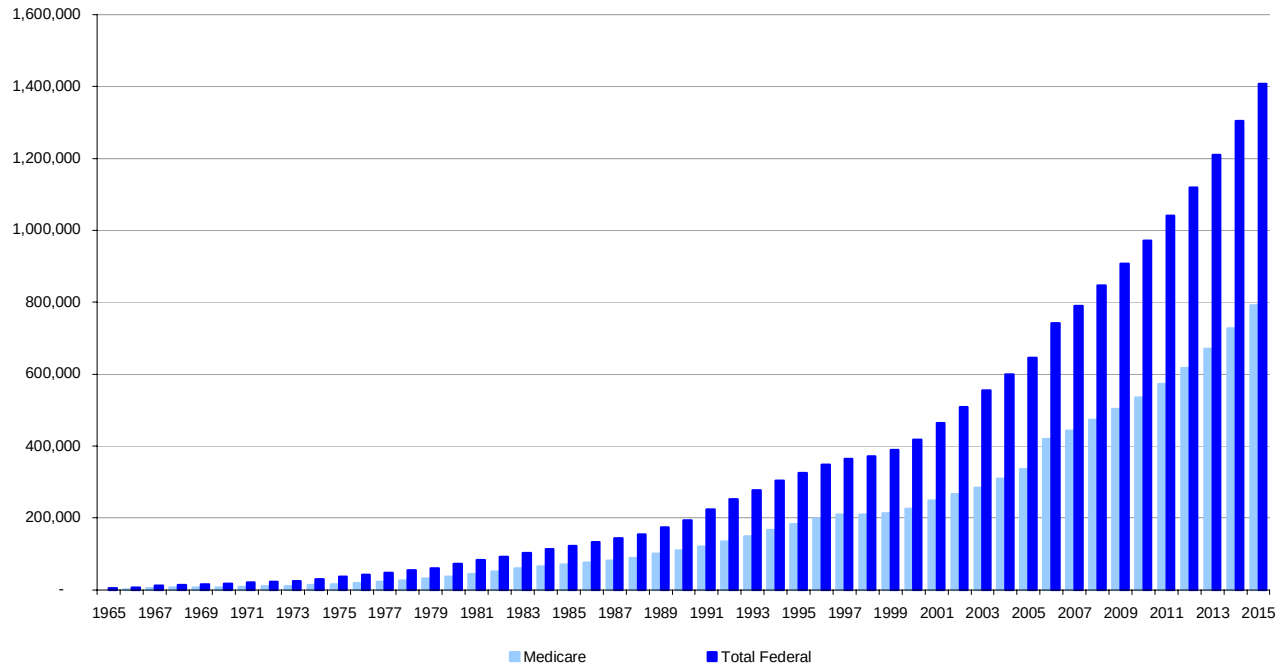
have excellent substitutes still enjoy high marginal profits. As we see it, the introduction of Medicare Advantage, i.e., a free enterprise system, also represents the introduction of the laws of economics to health care. If successful, we believe manufacturers of products with good substitutes will earn something closer to their marginal cost of production, which is a long, long way down from what they earn today.

- **Controlling Volumes: Is the Fox Watching the Hen House?** Medicare pays physicians for each billable thing they do rather than a fixed salary or for outcomes. This system encourages high volumes. We believe Medicare provides almost no oversight and does almost nothing to identify and "fire" or even withhold reimbursement to physicians that abuse this privilege. We believe Medicare essentially presumes that if a physician has a license to practice medicine, then he or she can be trusted to make the right medical decisions.

- A significant number of physicians do not follow evidence-based guidelines when providing care. We believe Medicare has the best data to identify those physicians and facilities but refuses to make it available. So, the iron triangle is hurting our health, as well as using taxpayer dollars. This is aside from the fraud and abuse that we read about, e.g., when the FBI found surgeons performing unnecessary or risky heart surgery to make a buck. Cardiology and orthopedics fields are ripe targets because Medicare is the biggest payer today and there is a grey area on what really is and is not medically necessary. There are also variations in quality that lead to more re-work, and an improvement in quality by steering patients to better physicians and facilities can also reduce overall volume from readmission to hospital. A 1999 Institute of Medicare report and follow-up reports found that physician error is a leading cause of death in the United States.

Figure 13. Total Federal Health Care Spending and Medicare Spending

$ in millions, except per share data



Source: Centers for Medicare and Medicaid Services (CMS)

Is This Important to Managed Care Organizations?

- Yes, but not all of them. Those in the Medicare Advantage business will enjoy faster earnings growth, while those not participating will see their competitiveness erode.
- Each Medicare customer brings in about four times the revenues at about one-half the profit margin of a commercial customer.
- Medicare Advantage is bringing new customer and revenue growth to the industry that also provides increased leverage over suppliers of health care products and services. Greater leverage may accrue benefits to the commercial franchise of those plans. MA will therefore erode the relative network discounts enjoyed by today's large commercial plans that do not participate in MA. Worse, it could drive up their commercial rates if providers "cost shift" to avoid erosion to their top line.

Is Medicare Growth Enough to Offset Slowing Commercial Growth?

One of the bear cases for the managed care industry is that Medicare is not enough to offset slowing commercial growth.

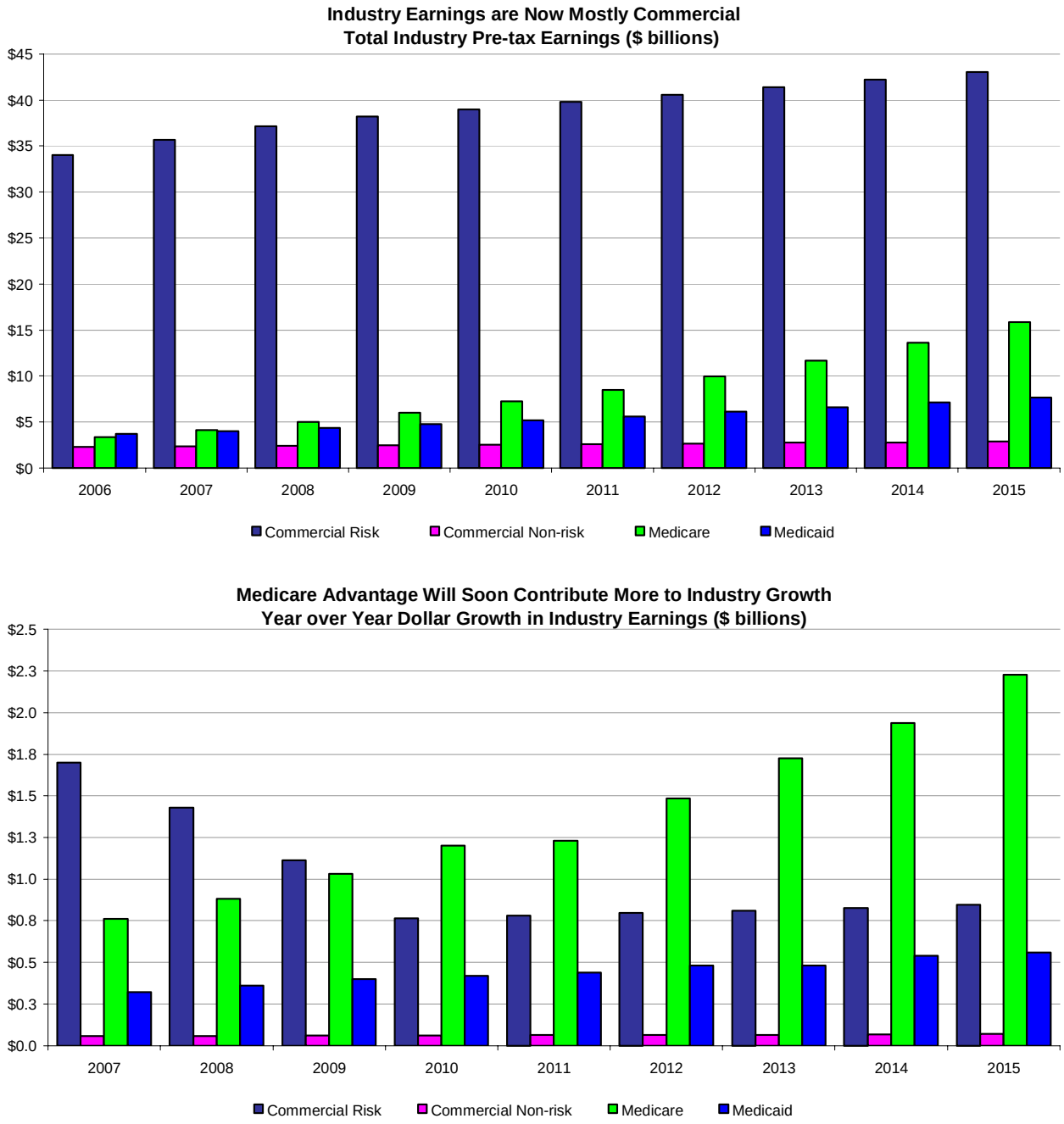
That is true for some companies like pure-play commercial plans Aetna and CIGNA, but it is clearly not true for companies like Humana and HealthSpring.

Obviously, a sound bite is not enough to respond to this bear case. The point we make is that history cannot be used as a guide for picking stocks in the managed care group today. The commercial and Medicare businesses are each at different points in their cycles and each company's exposure to both varies.

We believe the contribution to industry earnings growth from Medicare will be greater than the contribution from commercial by 2010.

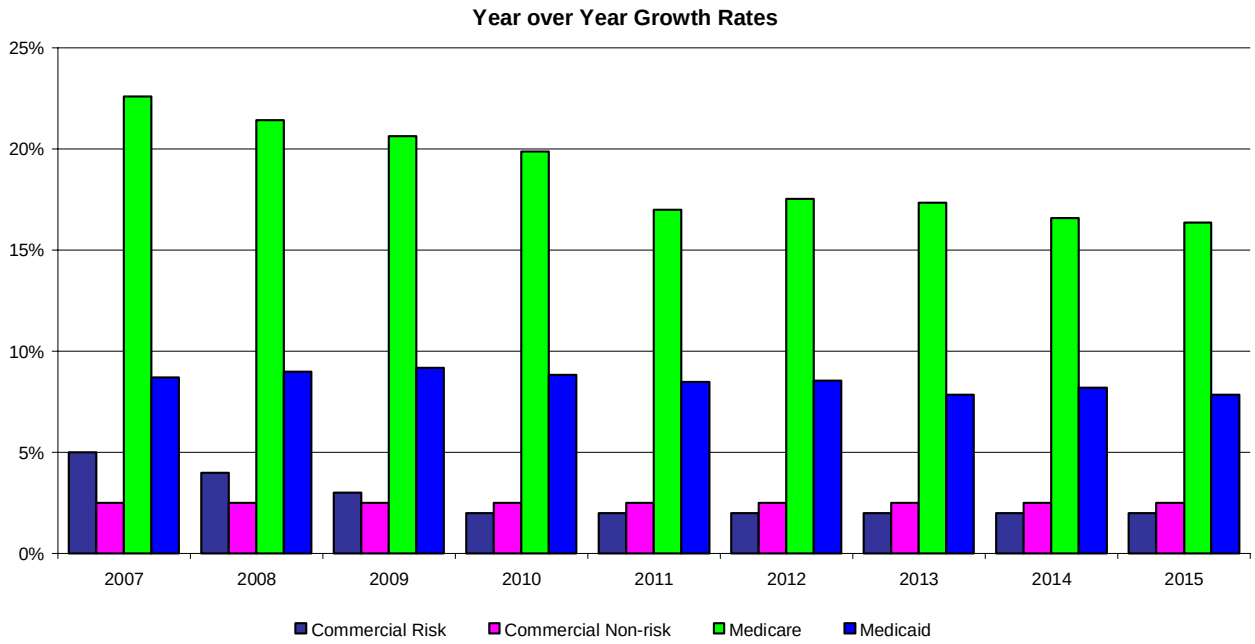
- **Estimate Earnings Growth for Each Company.** We build bottom-up models for each individual company. The commercial business is late in an elongated business cycle and entering a new product cycle that is more consumer-directed. Therefore, we believe companies have a choice of pricing for stable margins and low customer growth or accepting lower margins to grow the top line. Companies growing top line and participating in Medicare can price the commercial business for stable margins. Those not participating in Medicare may be more tempted to price commercial business for top-line growth, in which case they risk margins declining more than the top line grows.
- **Then Value Each Company.** We value each company by ascribing a P/E ratio based on the long-term earnings growth prospects including our assumptions for commercial, Medicare, Medicaid, and other business. We use a PEG ratio of between 1.0 and 1.4, which actually gives Medicare a discount PEG ratio versus its peers because of the government risk.

Figure 14. Industry Model Benefits from Medicare, but Not All Companies



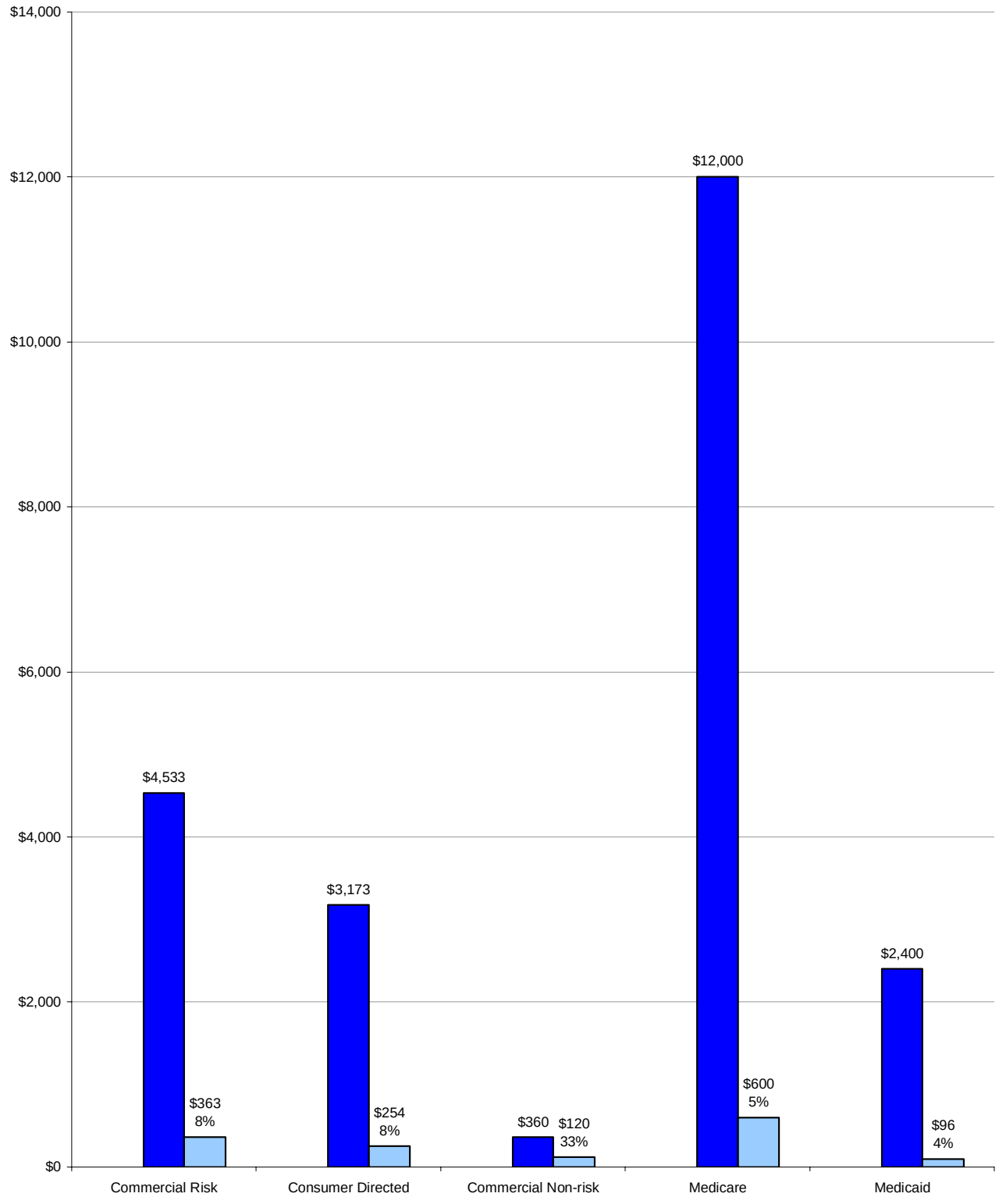
Source: Company reports and Citigroup Investment Research

Figure 15. Industry Model Benefits from Medicare, but Not All Companies (continued)



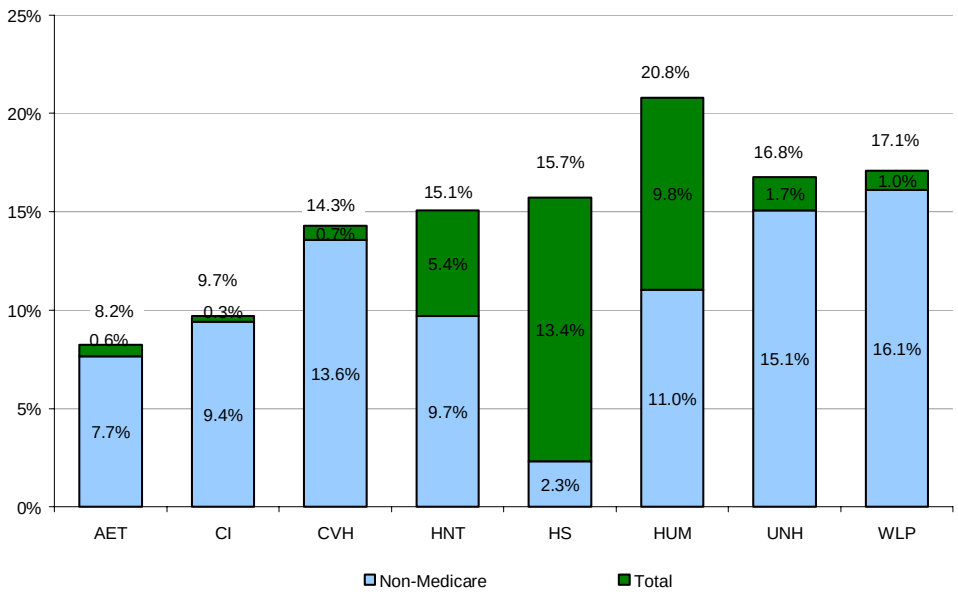
Source: Company reports and Citigroup Investment Research

Figure 16. Revenues and Pretax Profit per Customer per Year



Source: Citigroup Investment Research

Figure 17. Medicare Boosts 2006–09 EPS CAGR

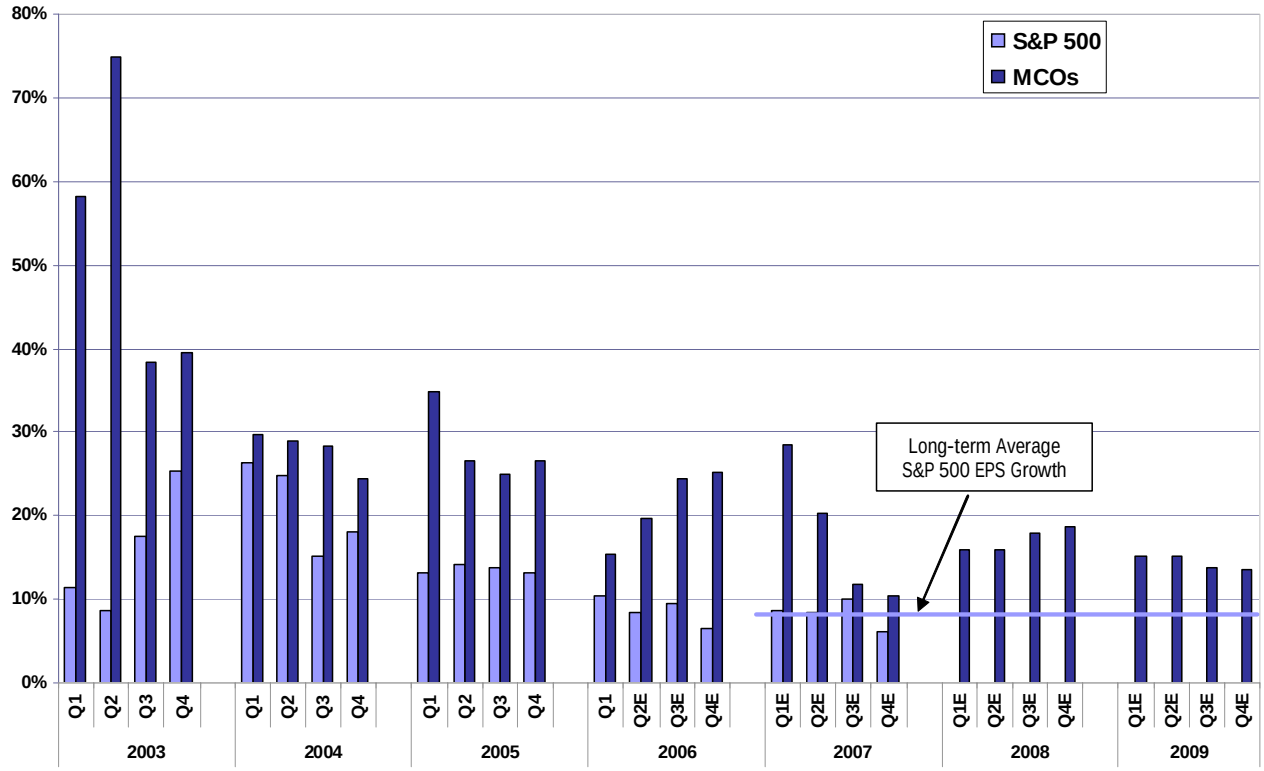


Source: Company reports and Citigroup Investment Research

Managed Care Investment Case

Our 12-month to three-year outlook remains bullish based on EPS growth at a reasonable price, or "GARP." The industry bear case has been that EPS growth is decelerating. While EPS growth decelerates, we forecast managed care organizations will grow earnings approximately two times faster than the long-term average EPS growth of the S&P 500 over the next three years. The group trades at valuations that are generally in line with the S&P 500 on our estimated forward 2006–07 EPS.

Figure 18. 2003–09E EPS Growth Exceeds S&P 500 (a)



a) Market-cap weighted

Source: Company reports and Citigroup Investment Research

Specifically, we look for the elongated commercial business cycle to continue on its path of deceleration. We see a contemporaneous handoff to accelerating Medicare growth offsetting commercial deceleration for some companies.

See our January 12, 2005 note "Medicare Handoff Elongates Cycle." Also see our October 3, 2005 "Part D, Round 2: Models and Methodology Behind Our 2006 Year 1 Projections" note elaborating on that thesis with detailed 2006 projections by company for Part D stand-alone and Medicare Advantage.

See Appendix for our key commercial assumptions and bear case.

We expect a handoff to accelerating Medicare growth to offset slowing commercial growth over the next three to five years. We believe the most compelling investment story is in Medicare — a very large and relatively untapped end market that offers de novo industry growth and an opportunity to increase leverage over providers of health care products and health care services to gain a cost advantage in the commercial business.

MCOs stand to greatly benefit from the expansion and privatization of Medicare. The *expansion* of Medicare to subsidize private drug insurance known as Part D prescription drug plans (PDPs) began in January 2006. It is a new and permanent entitlement. Health plans will be participating in Part D both nationally and in certain select states through Medicare Advantage-Prescription Drugs (MA-PD) and

stand-alone PDPs. New revenues to the industry are estimated to be in the $60–$70 billion range by 2008 and include monthly premiums from customers plus monthly payments from the federal government to the health plan.

The *privatization* of Medicare is taking place via a voucher-like program whereby seniors buy private health insurance from MCOs (known as Medicare Advantage) and the health plan receives a monthly "voucher" from the federal government. In addition to the Medicare HMO and Medicare PPO options in Medicare Advantage, MCOs are offering private fee-for-service (PFFS) plans that target seniors in traditional Medicare who are buying supplemental (Medigap) insurance. In 2006, MCOs will also broaden its Medicare options by adding regional PPOs.

A Big Change from Our 2006 Trading Outlook: In 2006, we have remained bullish on the managed care sector based on our 12-month outlook, and that long-term outlook remains the same. However, we make a big change in our near-term outlook.

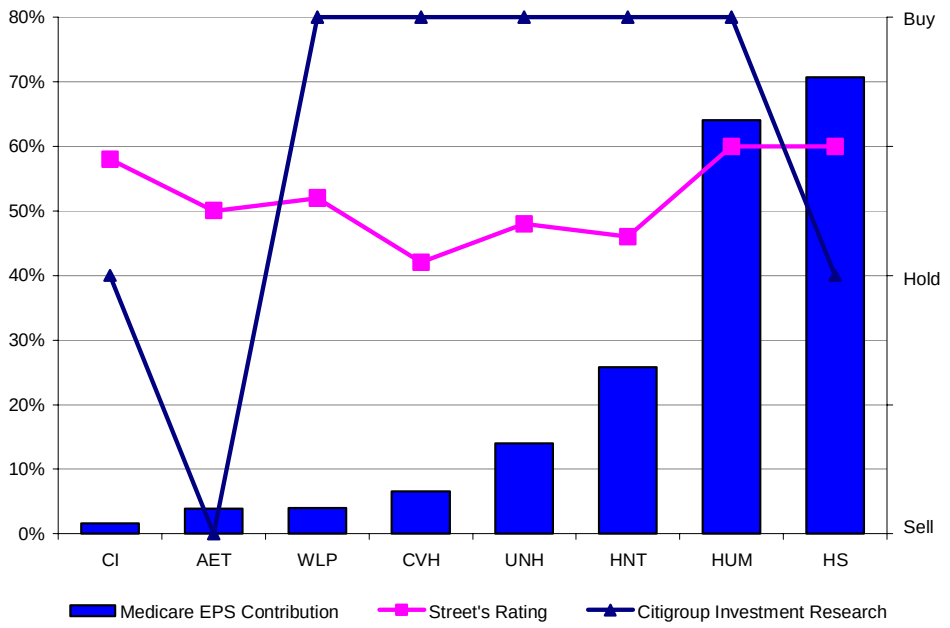
- *Previous Near-Term View:* On January 12, we saw "...little room for...upside near-term" and "higher volatility" in the stocks. That cautious view was based mainly on the high valuations in the group following almost 50% appreciation in our managed care index in each 2004 and 2005 versus 3% and 8% rises in the S&P 500 those years, respectively.
- *Current Near-Term View:* We now see "near-term significant upside potential and lower volatility" in managed care stocks.
- Expect in second half 2006 bifurcation of Medicare, early cycle, from commercial, late cycle. Our near-term trading Buys include: WLP, HUM, and CVH. Investors should avoid commercial large employer pure plays AET and CI.
- *Why the Reversal of Our Near-Term Opinion?* The following things have changed:

1) Valuations year to date have dropped 17% to the low end of the normal forward P/E range from high-end of that range. See valuation charts in Figures 19 and 20.

2) Medicare Advantage and Part D are progressing ahead of plan. In 2005, Medicare HMOs were the best performing stocks in the sector while tremendous uncertainty remained around the new Part D program and changes to reimbursement for Medicare Advantage. Today, with the first quarter results reported and almost one-half the year over, we have better visibility on Medicare.

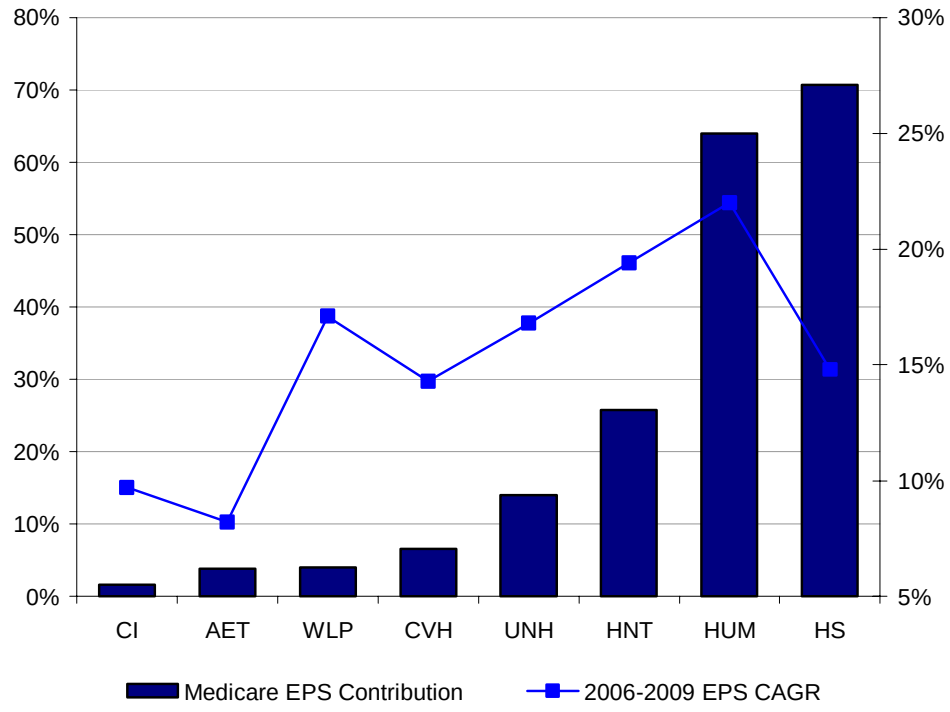
3) The commercial cycle is in a soft landing. Our nonprofit health care conference featured many large hospital systems throughout the U.S. that pointed to an easing of price increases and continued softness in volumes. Decelerating medical trends mitigate the risk of a business cycle turn. As nonprofit and mutually owned health plans have been pricing below trend to bleed excess capital, and with CIGNA, and maybe AET, priced for a higher medical loss ratio, we do not see an inflection point for the industry. An industry inflection point that would concern us would be an acceleration in medical costs.

Figure 19. The Street Is Not as Bullish on Medicare



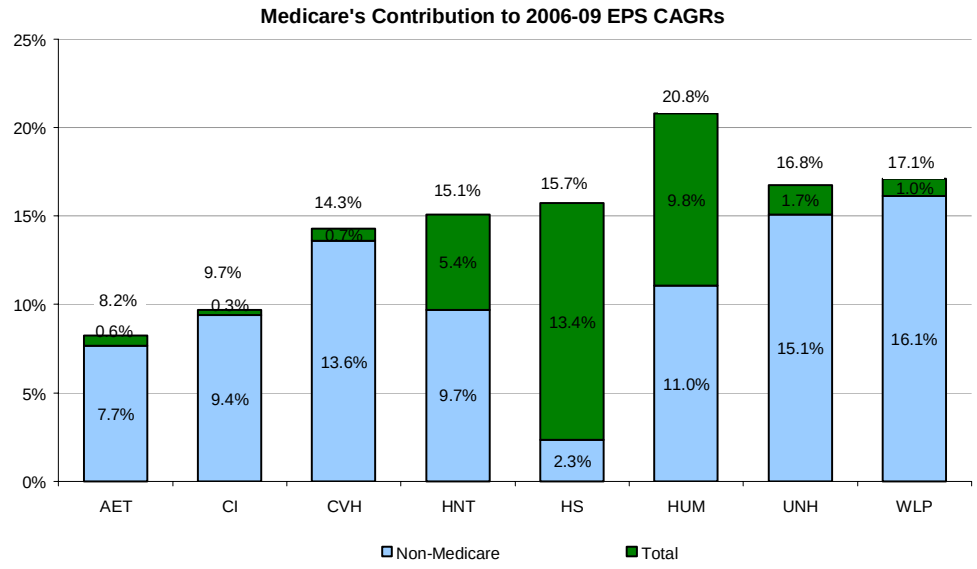
Source: First Call and Citigroup Investment Research

Figure 20. Medicare Exposure Will Drive Faster EPS Growth



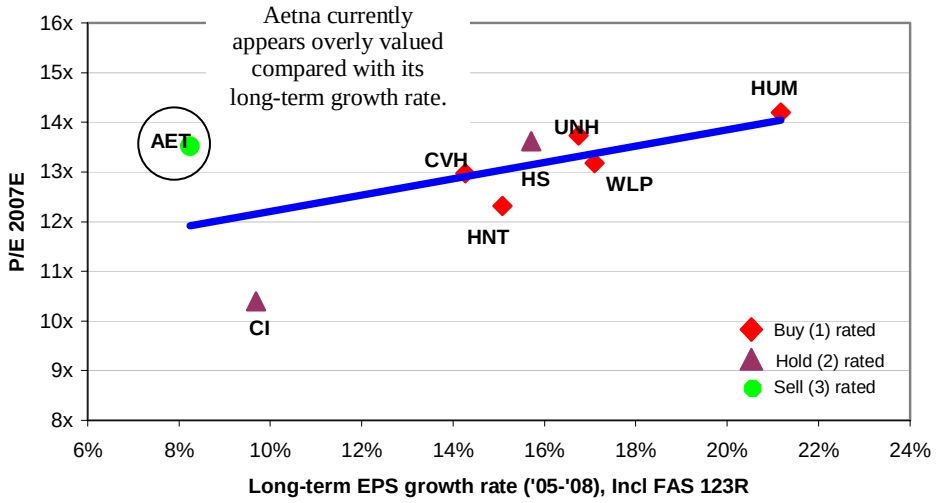
Source: Company reports and Citigroup Investment Research

Figure 21. Medicare Will Boost Commercial Growth through Overhead and Provider Leverage



Source: Company reports and Citigroup Investment Research

Figure 22. Street Opinion May Be Too Cautious on Medicare, or Too Bullish on Commercial



Source: Company reports and Citigroup Investment Research

Who Is Best Positioned to Benefit?

- *Investment Conclusion Bullish for the Medicare Market:* Managed care organizations should profit from an accelerating top line and greater leverage over providers of health care products and services, also making MCOs a good hedge in a health care investment portfolio.

- *Avoid Commercial Risk Business...* Our "Hello HSA, Goodbye HMO" report and our quarterly *Seasonal Playbook* presents our opinion on the commercial cycle in more detail. The commercial profit cycle was elongated versus previous cycles and remains in what we consider a "soft landing" of decelerating

top line and stable margins. Some companies, in particular nonprofit or mutually owned companies, accept a lower profit margin and even losses to bleed excess capital back to customers or to satisfy Wall Street's demand for top-line growth that achieves a higher P/E multiple. Our work shows the commercial business trades at a premium P/E-to-growth, or "PEG," ratio to the Medicare business even though we find the risks are high and it is late in the cycle for the commercial business.

- ...*Except as Part of a Medicare Book.* An important point of differentiation in our view versus Street opinion on the commercial cycle is that we believe companies with a strong Medicare franchise will be able to run their commercial business more profitably than others are able to, as overhead is absorbed and greater provider discounts should be achieved. Also, new market entry for Medicare can open the door to new commercial growth.
- *We do not see a negative inflection point for the industry.* We do not see evidence of an industrywide cycle turn that would be driven by acceleration in medical cost trends. Actually, we are seeing the opposite, i.e., continued deceleration in medical costs.

Figure 23. Managed Care Comparables

			AET	CI	CVH	HNT	HS	HUM	UNH	WLP	HMO Avg.
Ratings			3M	2H	1M	1H	2S	1M	1L	1L	
	Street Rating		2.1	2.6	2.4	2.9	2.6	2.7	2.0	2.0	2.4
Capitalization	Market Cap		23,938	11,611	8,716	5,424	974	8,560	65,764	51,179	22,020.7
($mn)	Total Debt ('06)		1,616	1,338	796	365	0	931	7,523	6,664	2,404.1
	Book Equity ('06)		10,340	4,215	3,184	1,913	557	2,968	14,825	23,804	7,725.8
	Tangible Book Equity ('06)		5,112	2,605	2,769	1,115	470	1,720	(3,675)	948	1,383.1
	AIC (b) Current		11,671	4,553	3,820	2,168	557	3,869	22,063	30,468	9,896.2
	AEV (c) Current		25,269	11,949	9,352	5,679	974	9,462	73,002	57,843	24,191.1
Stock	**6/7/2006**		**$40.36**	**$94.77**	**$53.36**	**$45.81**	**$16.97**	**$51.16**	**$46.28**	**$71.75**	--
Price	Target (d)		$36.00	$109.00	$68.00	$58.00	$20.00	$72.00	$81.00	$99.00	--
	% Upside		-11%	15%	27%	27%	18%	41%	75%	38%	29%
	52-wk Hi		$52.48	$133.77	$61.88	$54.11	$24.19	$58.26	$64.61	$80.40	--
	52-wk Lo		$34.83	$88.05	$44.33	$35.02	$15.41	$37.20	$41.44	$65.06	--
Valuation	P/E 2006E	@ Current Price	14.4	11.2	15.0	14.7	15.5	17.9	15.8	15.3	15.0
Ratios		**@Target Price**	**12.9**	**12.9**	**19.1**	**18.6**	**18.3**	**25.1**	**27.7**	**21.0**	**19.5**
		Current PEG	1.7	1.2	1.1	1.0	1.0	0.9	0.9	0.9	1.1
		Target PEG	1.6	1.3	1.3	1.2	1.2	1.2	1.7	1.2	1.3
	P/E 2007E	@ Current Price	13.4	10.1	13.0	12.5	13.1	14.0	13.6	12.9	12.8
		@Target Price	**12.0**	**11.6**	**16.6**	**15.9**	**15.4**	**19.7**	**23.8**	**17.8**	**16.6**
		Current PEG	1.6	1.0	0.9	0.8	0.8	0.7	0.8	0.8	0.9
		Target PEG	1.4	1.2	1.2	1.1	1.0	0.9	1.4	1.0	1.2
	P /	Book	2.3	2.8	2.7	2.8	1.7	2.9	4.4	2.1	2.7
		Tangible Book	4.7	3.0	4.1	6.2	1.9	6.6	NM	46.4	10.4
	Free Cash Flow Yield ('06E)		4.4%	10.4%	12.1%	10.5%	25.0%	6.5%	6.5%	8.2%	10.4%
	AEV/	Free Cash Flow ('06E)	23.8	9.9	8.9	10.0	4.9	17.0	17.2	13.8	13.2
		@Target Price	**21.4**	**11.4**	**11.1**	**12.5**	**4.7**	**23.3**	**28.8**	**18.5**	**16.5**
	AEV/	Free Cash Flow ('07E)	14.4	9.9	11.5	18.8	7.7	12.2	11.0	15.3	12.6
		@Target Price	**12.9**	**11.3**	**14.5**	**23.6**	**7.4**	**16.7**	**18.4**	**20.5**	**15.7**
	AEV	Current Sales ('06E)	1.0	0.7	1.2	0.4	0.8	0.4	1.0	1.0	0.8
	Current/	Insured Member ('06E)	4,675	5,831	3,378	1,655	3,938	2,958	4,184	3,297	$3,740
		Total Member ('06E)	1,599	1,304	3,596	1,601	3,938	2,044	2,544	1,663	$2,286
	AEV/	EBITDA ('06E)	15.2	7.7	9.3	10.1	9.1	12.9	10.6	11.4	11.0
		@Target Price	**13.6**	**8.9**	**11.7**	**12.6**	**8.7**	**17.6**	**17.8**	**15.3**	**13.3**
	AEV/	EBITDA ('07E)	13.6	7.8	8.2	8.6	8.4	10.4	9.0	10.0	9.5
		@Target Price	**12.2**	**9.0**	**10.3**	**10.8**	**8.0**	**14.2**	**15.1**	**13.3**	**11.6**
		EBITDA ('06E)	15.1	6.8	9.4	9.9	10.6	12.9	9.7	10.6	10.6
EPS	2005	1Q	$0.46	$2.24	$0.73	$0.55	$0.04	$0.53	$0.55	$0.94	
		2Q	$1.08	$1.98	$0.80	$0.55	$0.08	$0.51	$0.58	$1.00	
		3Q	$0.58	$1.94	$0.81	$0.67	$0.09	$0.60	$0.61	$1.02	
		4Q	$0.61	$1.98	$0.81	$0.65	$0.06	$0.46	$0.64	$1.05	
	2006E	1Q	$0.64	$2.11	$0.74	$0.65	$0.14	$0.39	$0.63	$1.10	
		2QE	**$0.64**	**$2.00**	**$0.83**	**$0.70**	**$0.27**	**$0.36**	**$0.68**	**$1.14**	
		Street consensus	$0.64	$1.93	$0.82	$0.66	$0.25	$0.35	$0.68	$1.14	
		Guidance - low	$0.63	$1.75	$0.80	$0.65	NG	$0.31	$0.67	$1.14	
		Guidance - high	NG	$1.90	$0.82	$0.70	NG	$0.36	$0.68	NG	
		3QE	$0.74	$2.13	$0.96	$0.85	$0.33	$1.05	$0.79	$1.21	
		4QE	$0.77	$2.22	$1.02	$0.92	$0.33	$1.06	$0.82	$1.25	
		2000	$1.35	$6.85	$6.85	$6.85	$0.00	$0.54	$2.25	$1.01	--
		2001	($1.96)	$7.07	$7.07	$7.07	$0.00	$0.70	$0.84	$1.52	--
		2002 (inc FAS142)	$0.57	$6.65	$1.06	$2.21	$0.00	$1.20	$1.06	$2.06	--
		2003	$1.20	$5.69	$1.84	$2.71	$0.00	$1.46	$1.38	$2.63	--
		2004	$1.54	$7.79	$2.48	$1.83	$0.50	$1.68	$1.87	$3.32	--
		2005 Reported	$2.16	$8.14	$3.15	$2.42	$0.28	$2.10	$2.50	$4.01	
		2005 Pro forma FAS123R	$2.06	$8.14	$3.06	$2.35	$0.24	$2.03	$2.38	$3.80	--
		2006E	**$2.80**	**$8.45**	**$3.55**	**$3.12**	**$1.10**	**$2.86**	**$2.92**	**$4.70**	**--**
		Street consensus	$2.75	$8.07	$3.49	$3.01	$1.05	$2.79	$2.92	$4.65	
		Guidance - low	$2.74	$7.50	$3.42	$2.94	$1.05	$2.82	$2.88	$4.63	
		Guidance - high	$2.76	$8.00	$3.48	$3.14	$1.12	$2.88	$2.92	NG	
		2007E	**$3.00**	**$9.40**	**$4.10**	**$3.65**	**$1.30**	**$3.65**	**$3.40**	**$5.55**	
		Street consensus	$3.16	$8.96	$3.97	$3.45	$1.25	$3.30	$3.38	$5.35	
		2008E	**$3.25**	**$10.25**	**$4.60**	**$4.20**	**$1.50**	**$4.25**	**$4.00**	**$6.55**	
		2009E	**$3.55**	**$11.15**	**$5.30**	**$4.75**	**$1.70**	**$5.05**	**$4.65**	**$7.55**	

			AET	CI	CVH	HNT	HS	HUM	UNH	WLP	HMO Avg.
EPS	Y - Y	1999	-67%	32%	32%	32%	NMF	-49%	-91%	NMF	-18%
Growth		2000	NMF	23%	23%	23%	NMF	-17%	468%	NMF	104%
		2001	NMF	3%	3%	3%	NMF	30%	-63%	50%	4%
		2002 (inc FAS142)	NMF	-6%	-85%	-69%	NMF	71%	27%	36%	-4%
		2003	NMF	-14%	74%	23%	NMF	22%	30%	28%	27%
		2004	28%	37%	35%	-32%	NMF	15%	36%	26%	20%
		1Q05A	16%	20%	33%	353%	-79%	28%	34%	17%	53%
		2Q05A	194%	13%	30%	20%	-59%	9%	32%	20%	32%
		3Q05A	53%	9%	27%	0%	-49%	15%	22%	22%	13%
		4Q05A	57%	-18%	20%	10%	-59%	66%	24%	24%	15%
		2005	40%	4%	27%	32%	-44%	25%	33%	21%	17%
		2006E vs '05 Pro Forma	**36%**	**4%**	**16%**	**33%**	**350%**	**41%**	**23%**	**24%**	**66%**
		1Q06A	39%	-6%	2%	18%	214%	-26%	14%	17%	34%
		2Q06E	**-41%**	**1%**	**3%**	**27%**	**258%**	**-30%**	**16%**	**14%**	**31%**
		2007E	7%	11%	15%	17%	19%	28%	16%	18%	16%
		2008E	8%	9%	12%	15%	16%	16%	18%	18%	14%
		2009E	9%	9%	15%	13%	13%	19%	16%	15%	14%
		L-T (06-09E)	**8.3%**	**9.7%**	**14.3%**	**15.1%**	**15.7%**	**20.8%**	**16.8%**	**17.1%**	**14.7%**

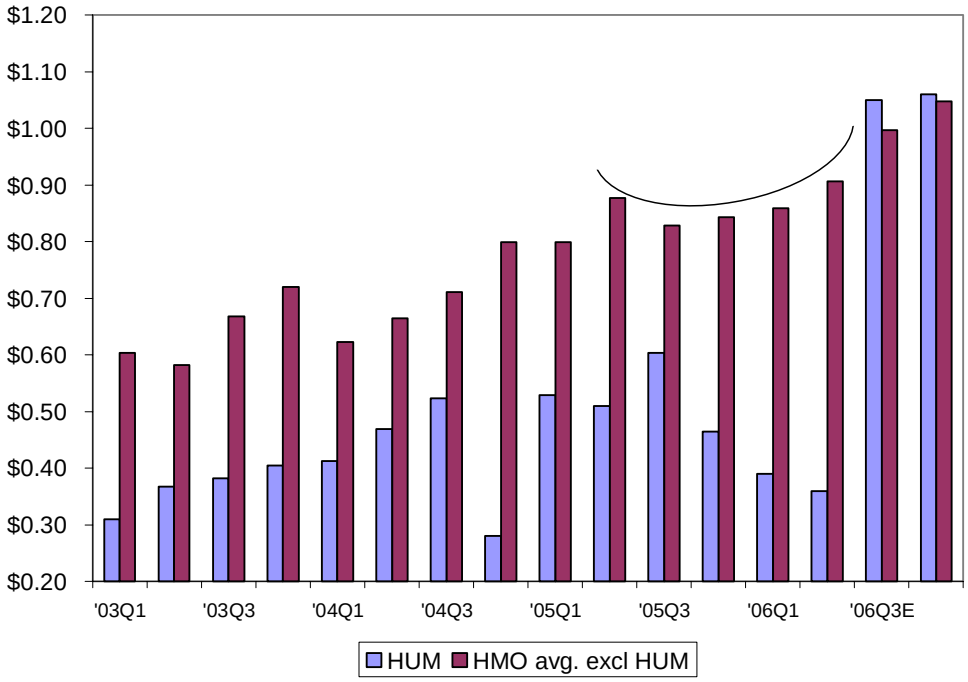
Source: Company reports and Citigroup Investment Research

But Seasonality of Earnings Will Change

EPS Deceleration in Second Half 2005 through First Quarter 2006 Should Be Followed by Sharp Acceleration in Second Half 2006

A smile-shaped curve can be seen when looking at quarterly EPS performance for managed care stocks from third quarter 2005 through second quarter 2006 (see Figure 24). We believe investors have been selling managed care stocks ahead of first quarter 2006 earnings, in part, because of that deceleration, even though we expect it will be followed by a period of acceleration that more than offsets the near-term slowdown. That smile-shaped curve of EPS growth reflects high startup costs in second half 2005 and first half 2006 related to the biggest expansion in Medicare in 40 years, or Part D drug insurance, which will be sold by managed care organizations. On top of that, the seasonality of earnings should change as result of Part D, because it loses money in the first quarter and makes money in the back half of the year.

Figure 24. HMO Acceleration to Occur in Second Half 2006



Source: Company reports and Citigroup Investment Research

Why the Seasonality on Part D?

Simply put, the way the product works is the health plan is responsible for paying up-front drug costs plus commissions. As the year progresses, the individual begins to pay into a "doughnut hole," or coverage gap. Then, after a threshold of drug expenses is passed, the government steps in to cover most of the costs. The reality is much more complex than what was just described, but it is the main point behind seasonality we expect from Part D. For more nuances please contact us or refer to other more detailed reports we published on Medicare (as listed in Figure 38).

The Biggest Risks Seem Company-Specific

In general terms, the biggest risk to an individual company is that it prices below the cost trend, creating a potential "hard landing" for the company and unfairly and temporarily taking market share from more disiciplined pricers. Why would a company do that? Nonprofit and mutually owned companies often have a mission to provide affordable health care to their communities; therefore, we say they run their business according to the balance sheet instead of the income statement. That is, they set prices to maximize the number of people to whom they can offer affordable health insurance, and excess capital on their balance sheet allows them to lose money in the process. Another example of why a company would intentionally price below the cost trend is a public company that wants to present a growth story to investors. Companies coming out of a turnaround situation, such as CIGNA and Aetna, that have excess reserves can afford to cut price to gain market share and present a story of top-line driven earnings growth. That could lead to a higher P/E multiple, attracting a growth investor that would pay for a top-line customer growth-driven earnings stream. However, as we saw in the reaction to first quarter 2006 earnings from CIGNA and Aetna, the Street does not take kindly to finding out about pricing below trend, which is evidenced by a higher medical loss ratio and growing commercial risk enrollment in a shrinking market, as well as depletion of excess reserves.

The Medicare-Industrial-Congressional Complex

A Farewell Address to the Nation — January 2009

Below, we modified the farewell address of the President of the United States and former Army General Dwight D. Eisenhower, delivered January 17, 1961, so that it may well prove to be apt advice to the nation at the close of the current administration. He coined the term "military-industrial complex" during the cold war. We draw a parallel to what we see as a Medicare-industrial complex today. The term "military-industrial-congressional complex" had been modified to drop "congressional" for the actual speech. We threw it back in. It refers to the "iron triangle" of weapons manufacturers (industry), the military, and U.S. Congress. Our parallel is that the health care industry today aggressively lobbies the U.S. Congress that in turn legislates a Medicare payment system to health care providers and manufacturers reminiscent of the military's $435 hammer, the $640 toilet-seat cover, the $659 ashtray, and the $3,000 coffeemaker.

My fellow Americans:

After eight years in the service of our country, I shall lay down the responsibilities of office as, in traditional and solemn ceremony; the authority of the Presidency is vested in my successor.

This evening I come to you with a message of leave-taking and farewell, and to share a few final thoughts with you, my countrymen.

Like every other citizen, I wish the new President, and all who will labor with him Godspeed. I pray that the coming years will be blessed with peace, prosperity, and choice of health plan for all seniors.

Our people expect their President and the Congress to find essential agreement on issues of great moment, the wise resolution of which will better shape the future of the Nation.

Congress and the administration have, on the vital issue of Medicare, cooperated well, to serve the national good rather than mere partisanship, and so have assured that the business of providing affordable and quality health benefits to seniors through Medicare Advantage signed in the Medicare Modernization Act of 2003 and implemented over the last five years, should go forward. So, my official relationship with the Congress ends in a feeling, on my part, of gratitude that we have been able to do so much together.

II.

We now stand eight years past the beginning of a century that has witnessed the tripling of the cost of health care to 15% of our GDP from 5% in the middle of the last century. Our own country has among the highest GDP per capita and still spends more on health care as a percent of GDP than any other country. Despite this high expense, America is today the strongest, the most influential and most productive nation in the world. Understandably proud of this preeminence, we yet

realize that America's leadership and prestige depend, not merely upon our unmatched material progress, riches, and access to health care, but on how we use our tax dollars in the interests of pursuing quality outcomes and human betterment. Government is a major reason for the high cost of health care. The federal and state governments now pay for more than 50% of all health care. It is my sincere hope that the migration of seniors in Medicare into Medicare Advantage plans, and the migration of the indigent into Medicaid HMOs, will result in better health care for those beneficiaries with fewer wasted tax dollars than the current government-run system fraught with waste, fraud, abuse. According to the Institutes of Medicine, physician error is a leading cause of death in the U.S. And taxpayers are providing the big financial incentive for provision of unnecessary care and ignoring evidence-based protocols.

III.

Throughout America's adventure in free government, our basic purposes have been to keep the peace; to foster progress in human achievement; and to enhance liberty, dignity; and integrity among people and among nations. To strive for less would be unworthy of a free and religious people. Any failure traceable to arrogance or our lack of comprehension or readiness to sacrifice would inflict upon us grievous hurt both at home and abroad.

Progress toward these noble goals is persistently threatened by the conflict now engulfing the debate on health care. It commands our whole attention, absorbs our very beings. We face a hostile ideology — global in scope and atheistic in character. Unhappily the danger it poses promises to be of indefinite duration. To meet it successfully, there is called for, not so much the emotional and transitory sacrifices of crisis, but rather those which enable us to carry forward steadily, surely, and without complaint the burdens of a prolonged and complex struggle — with free markets in health care the stake. Only thus shall we remain, despite every provocation, on our charted course toward permanent society of individual ownership and health betterment through free markets.

Crises there will continue to be. In meeting them, there is a recurring temptation to feel that some spectacular and costly action could become the miraculous solution to all current difficulties. A huge increase in new health care technology; development of unrealistic programs to cure every ill; a dramatic expansion in basic and applied health care research on goals as elusive as eternal youth and human cloning — these and many other possibilities, each possibly promising in itself, may be suggested as the only way to the road we wish to travel.

But each proposal must be weighed in the light of a broader consideration: the need to maintain balance in and among national programs — balance between the private and the public economy, balance between cost and hoped for advantage — balance between the clearly necessary and the comfortably desirable; balance between our essential minimum health care requirements as a nation and the duties imposed by the nation upon the individual; balance between actions of the moment and the national welfare of the future. Good judgment seeks balance and progress; lack of it eventually finds imbalance and frustration.

The record of many decades stands as proof that our people and their government have, in the main, understood these truths and have responded to them well, in the face of stress and threat. But threats, new in kind or degree, constantly arise. I mention two only.

IV.

A vital element in keeping the general welfare is our health care establishment. Our health care providers must be ready to provide immediate care so that no potential ailment such as a bad hip or knee may destroy a good day of golf.

Our health care organization today bears little relation to that known by any of our previous generations, or indeed most other countries, in terms of its almost unlimited access to care with little or no consideration to medical necessity, following evidence-based guidelines, or measuring outcomes.

Until less than 50 years ago, the United States federal government had no health care industry. Americans would, with time and as required, cover their own cost of care. But now, thanks to much advancement in medical technology including prescription drugs, and thanks to the reduction in retiree health benefits by many employers, we have been compelled to expand the already permanent Medicare entitlements by vast proportion with the creation of Part D drug insurance. Added to this, Medicaid is also contributing to the pressure on federal and state budgets providing benefits for the indigent including more than 6 million elderly. The federal government will absorb a great deal of those costs through Part D for seniors dually eligible for Medicare and Medicaid.

Your federal and state governments now annually spend on health care for the elderly and indigent an amount greater than the net income of all United States corporations. This conjunction of an immense Medicare establishment and a large health care industry is new in the American experience. The total influence — economic, political, even spiritual — is felt in every city, every State house, every office of the federal government and in just about every level of state and local government. We recognize the imperative need for this development. Yet we must not fail to comprehend its grave implications. Our toil, resources and livelihood are all involved; so is the very structure of our society.

In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the Medicare-industrial complex. The potential for the disastrous rise of misplaced power exists and will persist.

We must never let the weight of this combination endanger our liberties or democratic processes. We should take nothing for granted. Only an alert and knowledgeable citizenry can compel the proper meshing of the huge health care industry and Medicare machinery of funding care to seniors with our free market methods and goals, so that health security and liberty may prosper together.

Akin to, and largely responsible for the sweeping changes in our industrial-Medicare posture, has been the technological revolution during recent decades.

In this revolution, research has become central; it also becomes more formalized, complex, and costly. A steadily increasing share is conducted for, by, or at the direction of, the federal government.

Today, the solitary inventor, tinkering in his lab, has been overshadowed by task forces of scientists in laboratories and clinical trials. In the same fashion, the free university, historically the fountainhead of free ideas and scientific discovery, has experienced a revolution in the conduct of research. Partly because of the huge costs involved, a government contract becomes virtually a substitute for intellectual curiosity. For every old test tube there are now hundreds of computers conjuring up new molecules.

The prospect of domination of the nation's health care product manufacturers and service providers by federal allocations, and the power of money is ever present and is gravely to be regarded. Yet, in holding scientific research and discovery in respect, as we should, we must also be alert to the equal and opposite danger that public policy could itself become the captive of a scientific technological elite.

It is the task of statesmanship to mold, to balance, and to integrate these and other forces, new and old, within the principles of our democratic system — ever aiming toward the supreme goals of our free society.

V.

Another factor in maintaining balance involves the element of time. As we peer into society's future, we — you and I, and our government — must avoid the impulse to live only for today, plundering, for our own ease and convenience, the precious resources of tomorrow. We cannot mortgage the material assets of our grandchildren without risking the loss also of their political and spiritual heritage. We want democracy to survive for all generations to come, not to become the insolvent phantom of tomorrow.

VI.

Down the long lane of the history yet to be written America knows that this world of ours, ever growing smaller, must avoid becoming a community of health care haves and have-nots, and be instead, a proud confederation of mutual access to high quality care at an affordable price.

Such a confederation must be one of equals. The least healthy and wealthy must come to the hospital with the same means to finance necessary care as the healthiest and wealthiest, protected as they are by financial resources to buy supplemental or "Medigap" insurance and receive employer-provided retiree coverage. That table, though scarred by many personal bankruptcies caused by high health care costs for those without independent wealth or employer-provided benefits, cannot be abandoned for the certain agony of an autocratic one-size fits all health plan run by the iron triangle of the Medicare-Industrial Complex. Industry (i.e., the providers of health care services and manufacturers of health care products such as hospitals and device and drug manufacturers), lobby an elected Congress eager for reelection support, that then legislate Medicare (Centers for Medicare and Medicaid Services)

pay above market rates for health care products and services with little or no consideration for quality, outcomes, or the pursuit of evidence-based protocols.

Offering private alternatives to Medicare, with mutual access to care, is a continuing imperative. Together we must learn how to offer access to seniors, not with government mandate, but with choice and free enterprise. Because this need is so sharp and apparent I confess that I lay down my official responsibilities in this field with a definite sense of disappointment. As one who has witnessed the high cost of malpractice lawsuits and waste, fraud and abuse in the health care system in my home state — as one who knows that this drag on our economy could utterly destroy our competitive edge slowly and painfully built since our independence more than two hundred years ago — I wish I could say tonight that a more complete privatization of Medicare is in sight.

Happily, I can say that fiscal insolvency has been avoided at the federal and state level thanks to strong growth in our resilient economy driven in part by tax cuts. Steady progress toward our ultimate goal of seniors choosing Medicare Advantage has been made. But, so much remains to be done. As a private citizen, I shall never cease to do what little I can to help seniors advance along the road toward Medicare Advantage.

VII.

So — in this my last good night to you as your President — I thank you for the many opportunities you have given me for public service. I trust that in that service you find some things worthy; as for the rest of it, I know you will find ways to improve performance in the future.

You and I — my fellow citizens — need to be strong in our faith that all nations, under God, will reach the goal of equal access to high quality health care at an affordable price. May we be ever unswerving in devotion to principle, confident but humble with power, diligent in pursuit of the Nation's great goals.

To all the peoples of the world, I once more give expression to America's prayerful and continuing aspiration:

We pray that peoples of all faiths, all races, all nations, may have their great health care needs satisfied; that those now denied health benefits shall come to enjoy them to the full; that all who yearn for free enterprise in health care may experience its spiritual blessings; that those who enjoy practicing health care without micromanagement by the federal government will understand, also, its heavy responsibilities; that all who are insensitive to the needs of others will learn charity; that the scourges of poverty, disease and ignorance will be made to disappear from the earth, and that, in the goodness of time, all peoples will come to live together in a peace guaranteed by the binding force of mutual respect, love, and health care security.

God Bless America!

Medicare Basics

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

- **Part A** covers overnight or inpatient hospital stays and skilled nursing facility, hospice, and some home care. It is financed primarily by a 2.9% payroll tax split between employers and employees.
- **Part B** covers physician visits and other outpatient services, including home health care, durable medical equipment such as home oxygen, end-stage renal disease care in freestanding facilities, laboratory testing, and outpatient hospital care. General taxpayer revenues finance 75% of Part B, and Medicare enrollees pay the other 25% through a monthly premium deducted from their Social Security checks. The current monthly premium is $78.20. It rose 13%, to $88.50 on January 1, 2006.

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

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

The Single Medicare Advantage Card Versus Multiple Coverage Sources

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

Beginning January 1, 2006, Medicare beneficiaries were able to sign up for a voluntary Medicare drug benefit, known as Medicare Part D. They get their drug benefit through either a prescription drug-only private insurance plan (PDP) if they choose to continue to get the rest of their benefits through traditional government Medicare or through a Medicare Advantage plan offering drug and other medical benefits.

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

Beneficiaries in the traditional program will continue with their Medicare hospitalization coverage (Part A) and pay the $88.50 premium in 2006 out of their monthly Social Security check for Part B doctor care. They will also pay from their

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

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

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

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

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

Figure 25. Part D Benchmark

Avg. Plan Bid:

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

Statutory Split:

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

Premium Revenue:

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

Source: CMS and Citigroup Investment Research

Medicare Managed Care History and the Start of Privatization

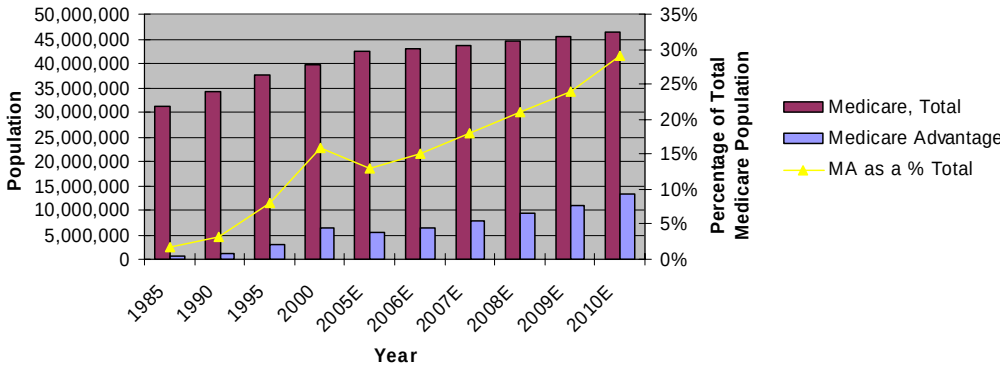
The federal government turned to managed care to help control Medicare spending growth early in the program's history. A key catalyst for growth of Medicare managed care came in 1982 with congressional passage of a law that allowed Medicare to pay HMOs a fixed fee that equaled 95% of the average cost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

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

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

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

Figure 26. Medicare and Medicare Advantage Enrollment, 1985–2010E



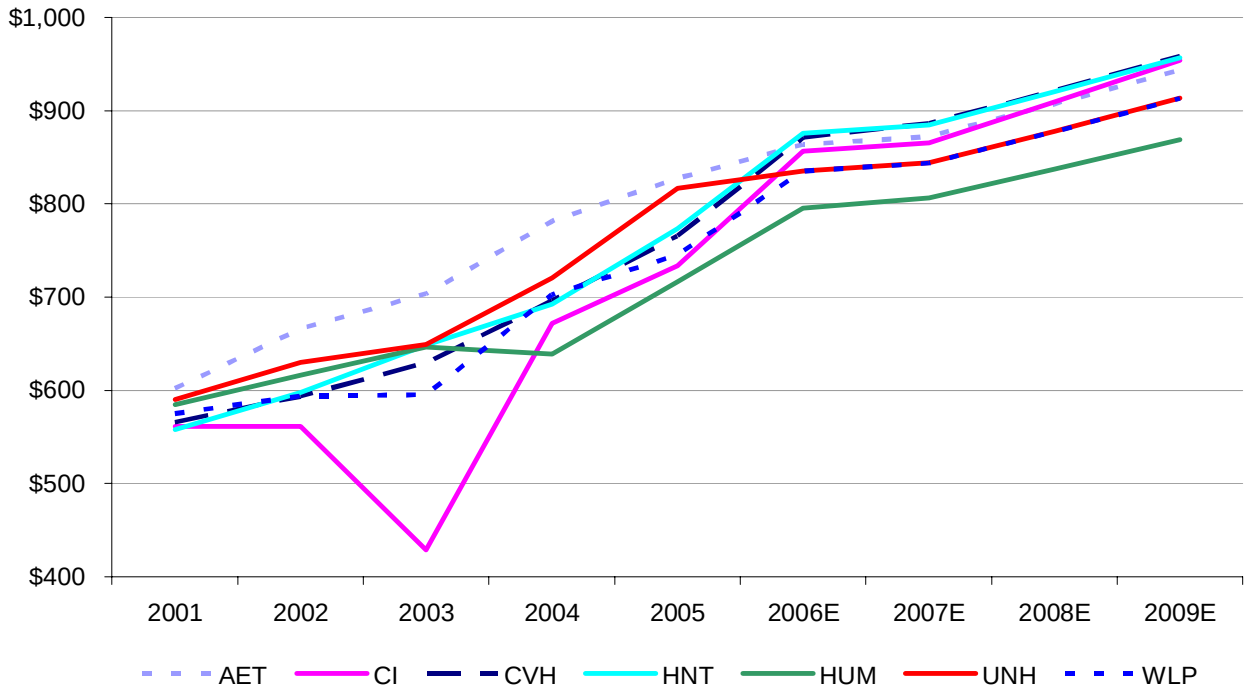
Source: Medicare Trustees Report (2005), Kaiser Family Foundation, CMS, and Citigroup Investment Research Estimates

The Medicare Modernization Act renamed the managed care program Medicare Advantage from Medicare+Choice and significantly increased payment. The payment formula was revised to pay a minimum of 100% of the average cost of a Medicare fee-for-service patient in a county. The law also folded teaching hospital spending into the rates. As a result, Medicare Advantage payment rose a minimum of 6.6% this year and significantly more in some counties. Reimbursement is scheduled to increase almost 5% next year.

The Medicare Payment Advisory Commission, an advisory panel to Congress, estimates that Medicare is actually paying plans an average of 107% of local fee-for-service cost of care. In its June report, the commission argued that Medicare is

paying health plans twice for teaching hospital care, once through fixed payment rate per person that Medicare makes to health plans and also through separate teaching hospital rates made to hospitals on behalf of the plans.

Figure 27. Medicare Advantage Revenues per Member per Month



Source: Citigroup Investment Research

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

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

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

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

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

- **Reinsurance:** The government picks up 80% of a plan's catastrophic costs after the coverage is triggered when a patient spends $3,600 out of pocket on drugs. Under the standard benefit design, that means catastrophic coverage would kick in at $5,100 in total drug spending.
- **Risk adjustment:** Medicare will adjust payments upward for, among others, low-income beneficiaries and for beneficiaries in nursing homes. Medicare officials have said payments to plans to cover low-income or nursing home patients with a number of co-morbidities could be significantly higher than standard rates of roughly 50% or greater.
- **Risk corridors:** The government will help cover a plan's losses if they exceed 2.5% of its spending target. A plan's spending target equals the prepayments by the government through direct subsidies and the beneficiary through premiums for basic benefit drug expenses. The government covers 75% of the second 2.5% of losses above the spending target and then 80% of any additional losses. The law, however, requires plans to share an equivalent amount of profits in excess of 2.5%.

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

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

Medicare Advantage Bidding

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

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

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

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

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

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

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

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

Regional Medicare Preferred-Provider Organizations

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

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

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

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

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

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

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

Humana will be a major provider of regional PPO network, providing coverage in 14 of 26 regions (23 states). Humana will most likely become one of the larger regional PPO players, especially given that PacifiCare and other Medicare players have not expressed an interest in pursuing that market at this point. Health Net will offer a regional PPO in Arizona, where monthly per member per month payments will be $714.46; Aetna will offer a PPO in the regions covering New Jersey, Maryland, Washington, D.C., and Delaware. Monthly reimbursement in the region covering Delaware, Maryland, and Washington, D.C. will be $769.61, and for the region covering New Jersey, $789.26. WellPoint will participate in California, Indiana, Kentucky, and Ohio, and UnitedHealth in Florida, Hawaii, and New York.

Figure 28. Medicare Advantage Regional PPOs

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

(1) Assumed weighting of demographic vs. risk, following county Medicare Advantage rates.
(2) Statutory vs. bid weighting for regional plans.

Source: CMS and Citigroup Investment Research

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

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

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

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

The Drug Benefit and Enrollment

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

The law and the administration's interpretation of law give PBMs and managed care plans many tools used in their commercial business to control costs, including tiered co-payments to encourage use of generic or preferred brands. At the same time, the

model formulary guidelines are similar to the structure of formularies in commercial offerings. These formularies are a model — a safe harbor for plans when negotiating with the government to offer a drug benefit. However, plans can negotiate variations of the formulary when contracting with the government to offer a Medicare drug benefit.

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

Figure 29. Part D EPS Contribution

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

Source: CMS and Citigroup Investment Research

We think employers will largely continue to provide retiree coverage in 2006 as a result of political pressure and a government pretax employer subsidy of $0.28 per $1 of allowable enrollee prescription drug costs between $250 and $5,000.

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

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

Figure 30. Drug Coverage for 2005E and 2006E

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

*Citigroup assumes most Medicare beneficiaries with coverage through the VA or Department of Defense will continue to get their coverage through them, because the coverage is better than under the standard Medicare drug benefit.

**an estimated 43 million in 2006

Source: Kaiser Family Foundation, CMS, and Citigroup Investment Research

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

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

Figure 31. Medicare Standard Drug Benefit

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

*Health plans required to provide actuarial equivalent benefit, but patient deductibles and co-payments may vary.

**Premium will vary based on plan bids.

Source: CMS

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

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

Figure 32. Comparison of Drug Costs for Universal vs. Insured Medicare Beneficiary

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

Source: Citigroup Investment Research

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

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

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

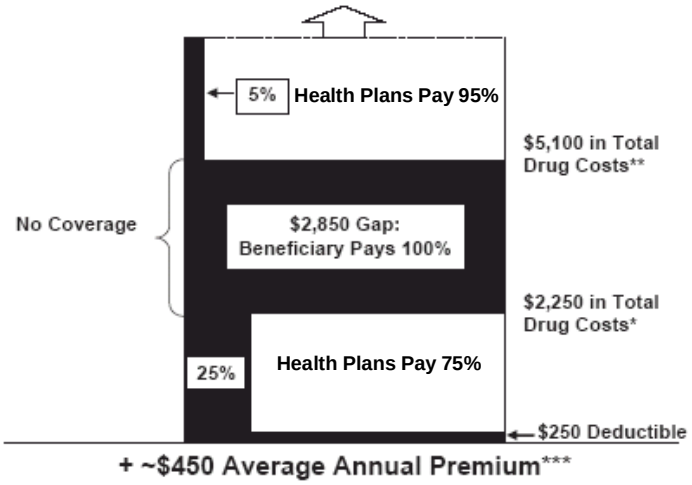
Here's why:

- The Bush administration and the health plans will likely spend hundreds of millions of dollars advertising the availability of a drug benefit. Because Congress created the drug benefit with little Democratic support, the political stakes for the Bush administration and Republicans are high, and they are making outreach a priority. Plans began marketing on October 1, 2006.

- Unlike with the drug discount card, Democrats are unlikely to launch full-scale attacks designed to discourage the elderly from signing up for the drug benefit. That's because many elderly, especially the poor and sick, benefit from the coverage. The Democrats so far are focusing their efforts on trying to amend the Medicare law to give the government direct control over negotiating drug prices — as opposed to leaving pricing solely to the health plans and PBMs — and squeezing Medicare reimbursement to the managed care plans. We do not think they will succeed at either this year.
- Finally, we point out that Medicare signed up more than 90% of the elderly at the start of the Medicare program in 1966 for the voluntary Part B doctor visit portion of the program. The premium was $3 a month — $18 in today's inflation-adjusted dollars. While $18 is lower than the average $32.20 a month drug benefit premium, we reiterate that managed care plans in 44 states will offer zero premium drug benefits, making the drug benefit attractive to many elderly. In addition, prescription drug insurance plans for under $20 a month are available in every state except Alaska, according to the CMS.

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

Figure 33. Standard Medicare Part D Benefit Design



*Equivalent to $750 in out-of-pocket spending. **Equivalent to $3,600 in out-of-pocket spending.
***Annual amount based on $37.37 monthly Part D premium estimate from 2005 Medicare Trustees report.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit described in the MMA of 2003.

*****Revised: ~$386 Average Annual Premium** based on CMS release of final 06 monthly Part D premium rates of $32.20 on 8/9/05.

Source: Kaiser Family Foundation illustration of standard Medicare drug benefit described in the MMA of 2003

To be sure, some plans will fill the coverage gap or doughnut hole under a benefits package negotiated with the CMS. Plans were allowed to, and did in many cases,

negotiate patient cost-sharing that differs from the arrangement in the diagram above. The different benefits designs are allowed as long as they are actuarially equivalent and not discriminatory.

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

Medicare beneficiaries with incomes below 150% of the federal poverty line ($14,355 for a single Medicare beneficiary and $19,245 for a couple) and whose assets fall below certain levels would receive considerable government assistance with out-of-pocket costs, including the elimination of the gap in coverage or doughnut hole. The CMS estimates that a total of 10.9 million of 14.4 million eligible low-income beneficiaries will sign up for the drug benefit in 2006.

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

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

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

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

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

A sampling of current programs in states with large state drug assistance programs or large elderly populations is shown in Figure 34.

Figure 34. State Drug Assistance Programs

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

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

Source: National Conference of State Legislatures, 2005

Wrap-Around Benefits

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

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

eligibility for new benefits would be 200% federal poverty level, with existing enrollees grandfathered at up to 250% federal poverty level.

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

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

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

Drug Utilization Boost

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

For seniors with employer retiree coverage, we think the shift is neutral to modestly negative. We expect modest erosion of employer retiree coverage in 2006. To the extent that employers drop retirees, this could be modestly negative. Employers generally offer more generous benefits than retirees would get under the standard Medicare drug benefit. Employers offering retiree drug coverage typically include drug spending as contributing to the overall plan deductible for health spending, do not charge an additional premium for coverage and do not have a gap in coverage, or doughnut hole, before the enrollee qualifies for catastrophic coverage, according to a December 2004 survey by Kaiser and Hewitt Associates, the human resources consulting firm. Eighteen percent of firms surveyed limit patient annual out-of-pocket drug spending (stop-loss), most commonly at $1,500, according to the survey.

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

additional medicine pricing discount of 5% more than they get in their commercial lines of business.

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

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

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

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

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

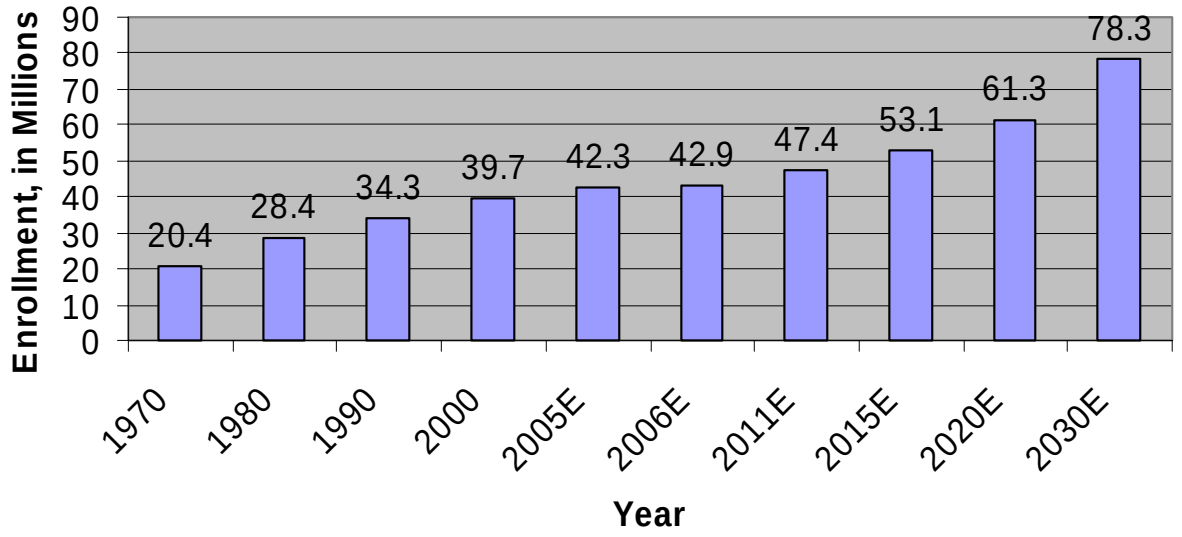
Overall, we think volume gains will offset price cuts under the drug benefit. Toward the end of the decade, however, we think Congress and a new administration in 2009 will face pressure to impose price controls on drugs. At the same time, generic drugmakers will benefit from congressional pressure to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

Future Risks

Medicare Spending Pressure

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

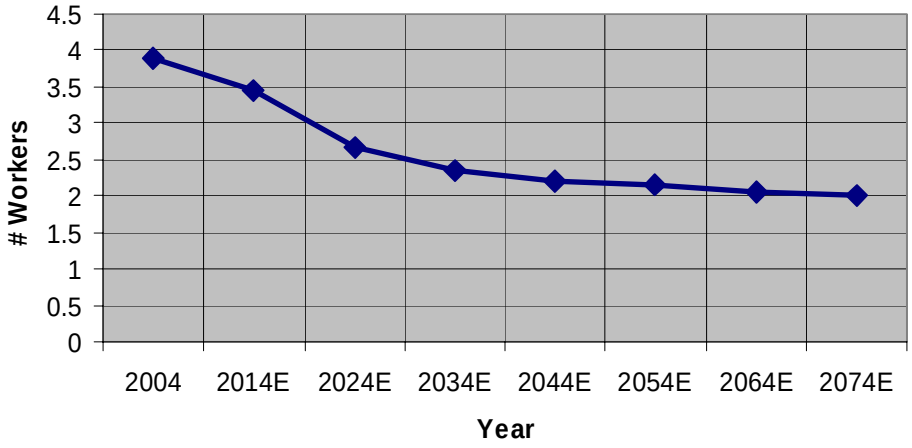
Figure 35. Medicare Enrollment, 1970–2030E



Source: Medicare Trustees Report, 2005

We expect the fast-track legislative process to be triggered in 2007, meaning the President would need to address this issue in his 2008 budget. Given that 2008 is a presidential election year, we think the trigger will help build pressure for containing Medicare spending growth in 2009. With baby boomers starting to turn age 65 in 2011 and thus qualify for Medicare upon retirement, lawmakers and the next president will also face pressure to control program finances. The projected surge in Medicare enrollment is coupled with the continued anticipated decline in the number of workers per beneficiary financing Medicare through payroll taxes. That poses a potential threat to Medicare payments to hospitals and other health providers, as well as to drugmakers at the end of the decade.

Figure 36. Workers per Medicare Part A (Hospital Insurance) Beneficiary



Source: Medicare Trustees Report, 2005

Timetable for Drug Benefit Implementation

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

Figure 37. Medigap Insurance

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

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

Figure 38. Related Industry Research

For more on our Medicare Views, please see the following reports:

April 4, 2006, "Medicare Managed Care Pay to Rise 1.1% on Average for '07"
https://www.citigroupgeo.com/pdf/SBD82296.pdf

March 2, 2006, "Our Health Care Conference in D.C."
https://www.citigroupgeo.com/pdf/SBD80976.pdf

February 20, 2006, "Medicare Proposes 6.9% Preliminary Managed Care Raise for '07"
https://www.citigroupgeo.com/pdf/SBD80312.pdf

February 16, 2006, "Medicare Handoff Elongates Cycle: Year 2"
https://www.citigroupgeo.com/pdf/SBD80218.pdf

February 2, 2006, "Medicare Managed Care Will Remain Growth Opportunity for '07"
https://www.citigroupgeo.com/pdf/SBD79286.pdf

January 17, 2006, "January Medicare Part D: Strong Enrollment at 80%+ of 28mn–30mn CMS Target"
https://www.citigroupgeo.com/pdf/SBD77985.pdf

December 6, 2005, "Medicare Part D Day Takeaways"
https://www.citigroupgeo.com/pdf/SBD76567.pdf

November 30, 2005, "2006–08 Medicare Advantage and Medicare Part D Assumptions"
https://www.citigroupgeo.com/pdf/SBD76411.pdf

October 3, 2005, "Medicare's $400 Billion Private Offering"
https://www.citigroupgeo.com/pdf/SBD72932.pdf

October 3, 2005 "Part D Round 2: Models and Methodology"
https://www.citigroupgeo.com/pdf/SBD72931.pdf

June 29, 2005, "Takeaways from Meetings with CMS"
https://www.citigroupgeo.com/pdf/SBD68452.pdf

March 30, 2005, "Our Health Care Conference in D.C."
https://www.citigroupgeo.com/pdf/SBD63952.pdf

January 12, 2005, "Medicare Handoff Elongates Cycle."
https://www.citigroupgeo.com/pdf/SBD59549.pdf

December 7, 2004, "Medicare Privatization Enhanced
https://www.citigroupgeo.com/pdf/SBD58194.pdf

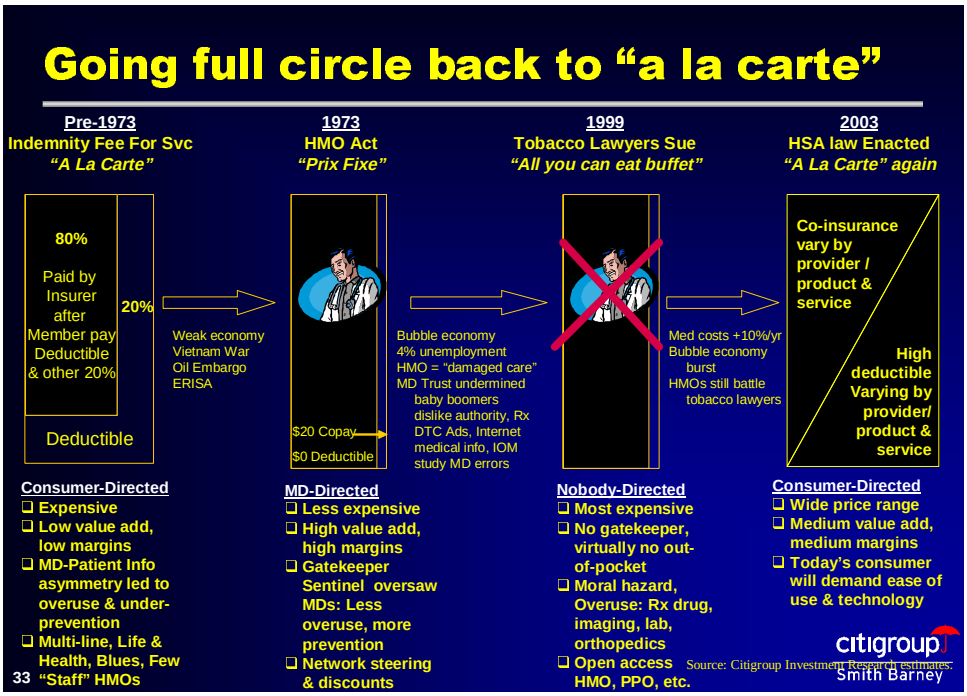
December 10, 2003, "Expect the Unexpected" (order no. US12L035)

Please contact your sales representative to obtain these reports.

Source: Citigroup Investment Research

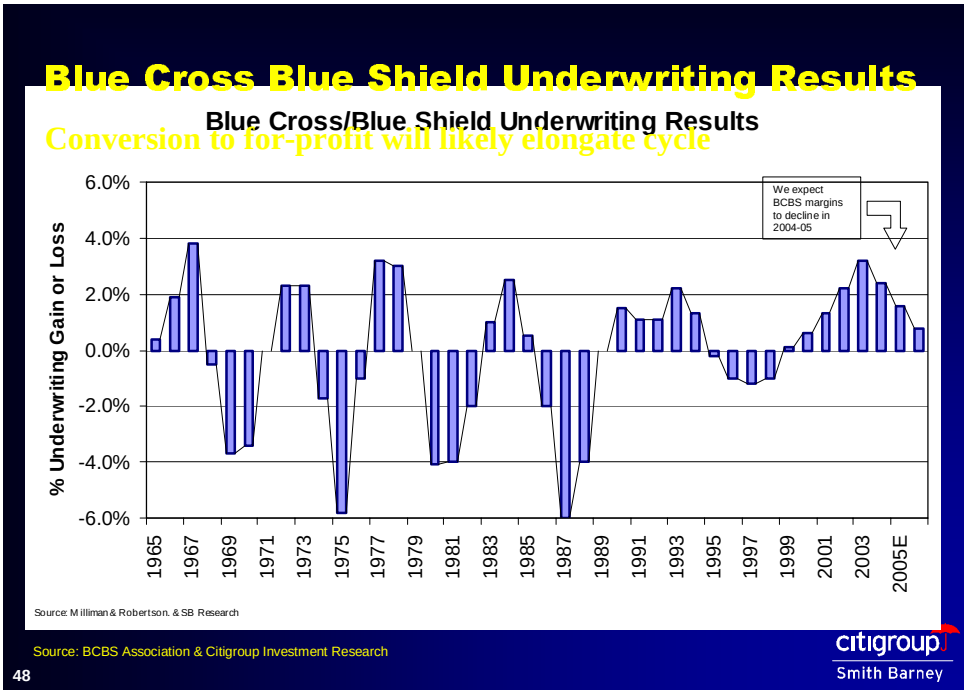
Appendix: Our Key Commercial Industry Assumptions

Figure 39. New Product Cycle to Consumer Directed



Source: Citigroup Investment Research

Figure 40. Blue Cross/Blue Shield Underwriting Results — Mainly Commercial



Source: Citigroup Investment Research

Figure 41. We Predict Commercial Premium Will Increase 2% in 2010

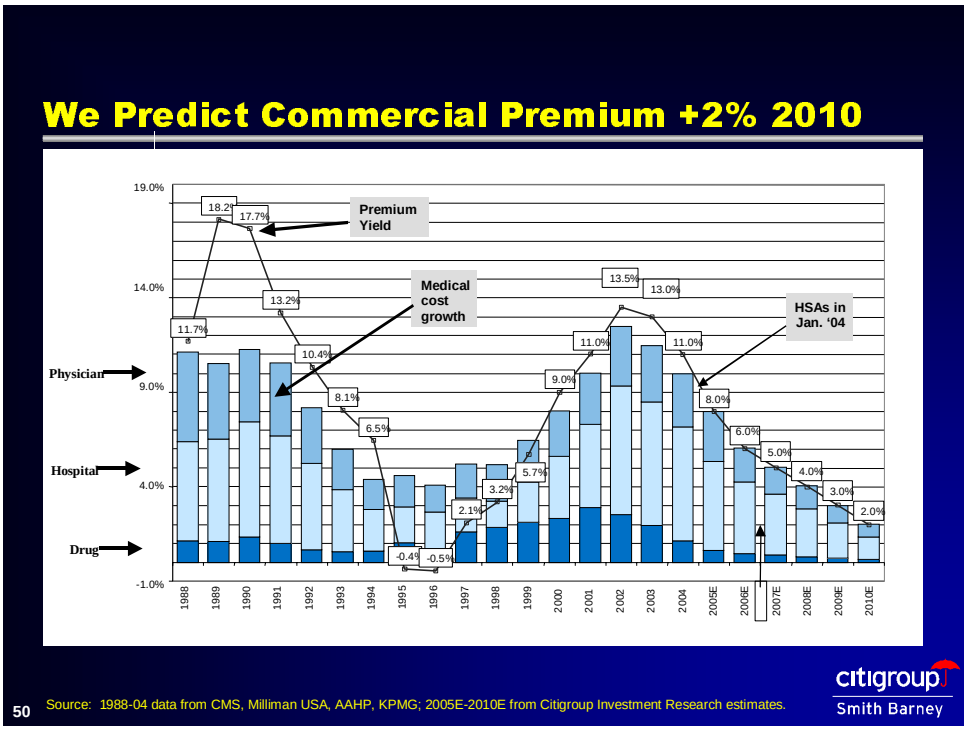
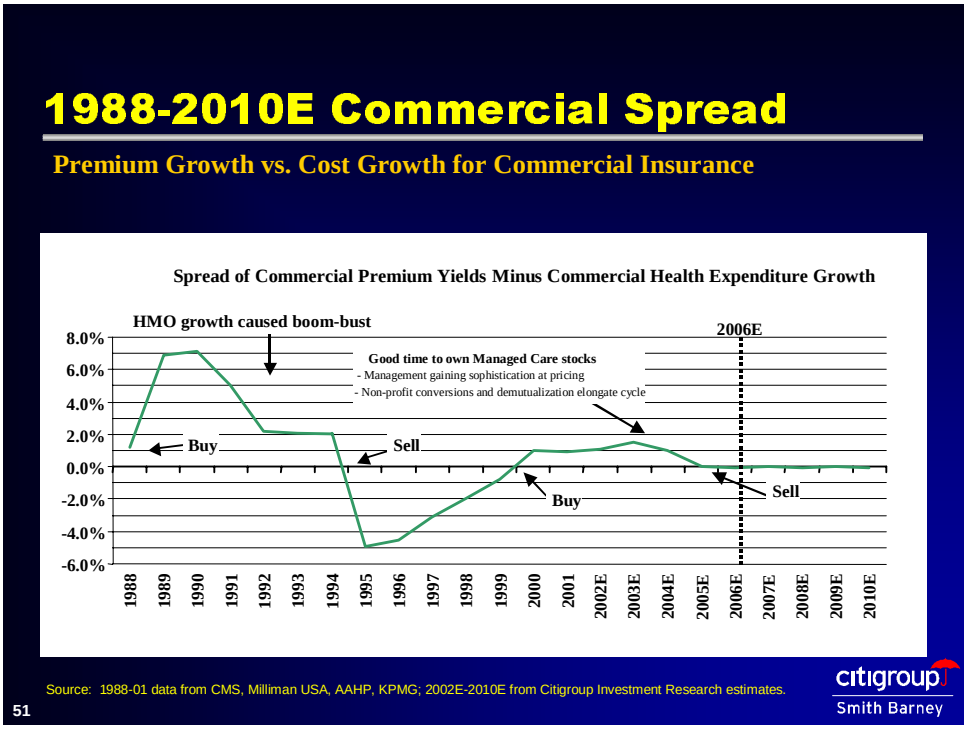


Figure 42. 1988–2010E Commercial Spread



The Bear Case?

The Street's ratings are fairly neutral, especially on Medicare-exposed Humana, although they remain more bullish on Aetna, United, and WellPoint. We observe that one of the key reasons for the Street's neutral or bearish views on the managed care group appears to be based on using history as a guide and pointing to the recent

outperformance of the group as a sign that the end must be near. However, we note that even the most bearish of Street analysts carry EPS projections that far exceed the expected growth of the S&P 500. So something is obviously different this time, and we believe history cannot be relied on to project the future, because of the rapidly changing dynamics of health care and also the conversion from nonprofit to for-profit.

Biggest Risks Appear Company-Specific. We believe the biggest single risk to our positive managed care stock opinion is company-specific and not industry- or macro-related. In our view, when something goes right or wrong for an MCO it is almost always because of management and execution. In that sense, the business cycle for managed care is not like industries, such as housing or automobile in which end market demand may dry up with a rise in interest rates. The demand for health benefits on the other hand does not vary widely from year to year, (although the privatization of Medicare may drive unusually strong new demand growth over the next several years). Instead, we believe the biggest risk to earnings is generally within the control of management of each company. It is the companies that cut prices and accept lower profit margins to keep or gain market share that generally wind up suffering earnings shortfalls. In other words, we believe it is generally a failure of management and not an outside force that is the cause of an earnings shortfall.

What is Different This Time?

Each of the three main customer end markets is going through a change that makes history an unreliable predictor of the future for managed care fundamentals, in our view:

1) *Elongated Commercial Underwriting Cycle.* The commercial cycle that was characterized by three years of profits followed by three years of losses is now in year 6 of profits. We continue to cite the conversion of nonprofits to for-profit, the demutualization of mutually owned companies, and the change in pricing discipline among nonprofits that plan to remain nonprofit as reasons for the elongation that we believe will be followed by a soft landing of premium deceleration to 2% yields by 2010E but stable margins.

2) *Medicare Handoff Elongates the Cycle.* As the commercial cycle has slowed, the Medicare cycle rapidly accelerated in 2005 with another injection expected in 2006. The Medicare end market is almost as big and will soon eclipse the commercial market in dollar size. Medicare has less than one-third the 150 million lives covered by employers. However, it is expanding to subsidize outpatient drug insurance and the per member cost is more than three times the cost to provide benefits to the average covered individual employee or dependent. The key to the long-term viability of Medicare privatization will be for the private sector over the course of the next few years to demonstrate to taxpayers and the government that the private sector can provide more utility for their tax dollars than the federal government-run Medicare. UnitedHealth Group's dominance in Medicare gives us conviction that the largest company in Medicare (pro forma for acquisitions) is also the company with the best data analytic capabilities and with a management that can prudently operate the business in a way that would, we believe, build government trust and respect.

3) *Medicaid Expansion and Privatization.* Medicaid is a $320 billion per year end market that over the past five years has expanded and moved toward privatization,

driving new customers and profits to the managed care group. While Medicaid lives generally do not increase leverage with providers the way commercial and Medicare do (because Medicaid rates are often deeply discounted and follow a state formula), they still provides a big boost in the size of the addressable market and the 50 various state cycles can mitigate the commercial cycle.

Believe Managed Care Stocks a Good Hedge in Health Care Portfolio

We see managed care as a good "hedge" for health care investors because medical expenses, the biggest expense items for MCOs, are the revenues for health care product manufacturers and service providers. Therefore, any unexpected deceleration in revenues for other health care companies could result in lower expenses and higher earnings for managed care. Major changes in each customer end market make the case more compelling to invest in managed care as a hedge. The commercial move to consumer-directed plans, the privatization of Medicare, and government focus on cutting growth in Medicaid, all present new opportunities and risks to the health care industry. The upshot appears to us to be more positive for managed care and negative for many providers of health care products and health care services.

Mergers Should Benefit Buyers and Sellers

We expect the pace of M&A among MCOs to remain strong in 2006–09. We do not build merger accretion into our models for acquisitions that have not been announced. As commercial earnings growth slows, companies not prepared for the "handoff to Medicare" may look to acquire other companies that position them well for Medicare. Possible acquisition targets that are exposed to Medicare include Humana and Health Net and to a lesser extent Coventry.

Table of Figures

Notes

ANALYST CERTIFICATION — Appendix A-1

I, Charles Boorady, research analyst and the author of this report, hereby certify that all of the views expressed in this research report accurately reflect my personal views about any and all of the subject issuer(s) or securities. I also certify that no part of my compensation was, is, or will be directly or indirectly related to the specific recommendation(s) or view(s) in this report.

IMPORTANT DISCLOSURES

Customers of the Firm in the United States can receive independent, third-party research on the company or companies covered in this report, at no cost to them, where such research is available. Customers can access this independent research at http://www.smithbarney.com (for retail clients) or http://www.citigroupgeo.com (for institutional clients) or can call (866) 836-9542 to request a copy of this research.

Analysts' compensation is determined based upon activities and services intended to benefit the investor clients of Citigroup Global Markets Inc. and its affiliates ("the Firm"). Like all Firm employees, analysts receive compensation that is impacted by overall firm profitability, which includes revenues from, among other business units, the Private Client Division, Institutional Equities, and Investment Banking.

For important disclosures regarding the companies that are the subject of this Citigroup Investment Research product ("the Product"), please contact Citigroup Investment Research, 388 Greenwich Street, 29th Floor, New York, NY, 10013, Attention: Legal/Compliance. In addition, the same important disclosures, with the exception of the Valuation and Risk assessments, are contained on the Firm's disclosure website at www.citigroupgeo.com. Private Client Division clients should refer to www.smithbarney.com/research. Valuation and Risk assessments can be found in the text of the most recent research note/report regarding the subject company.

Citigroup Investment Research Ratings Distribution

Data current as of 5 May 2006	**Buy**	**Hold**	**Sell**
Citigroup Investment Research Global Fundamental Coverage (2722)	41%	41%	17%
% of companies in each rating category that are investment banking clients	45%	42%	33%

Guide to Fundamental Research Investment Ratings:

Citigroup Investment Research's stock recommendations include a risk rating and an investment rating.

Risk ratings, which take into account both price volatility and fundamental criteria, are: Low (L), Medium (M), High (H), and Speculative (S).

Investment ratings are a function of Citigroup Investment Research's expectation of total return (forecast price appreciation and dividend yield within the next 12 months) and risk rating.

For securities in developed markets (US, UK, Europe, Japan, and Australia/New Zealand), investment ratings are: Buy (1) (expected total return of 10% or more for Low-Risk stocks, 15% or more for Medium-Risk stocks, 20% or more for High-Risk stocks, and 35% or more for Speculative stocks); Hold (2) (0%-10% for Low-Risk stocks, 0%-15% for Medium-Risk stocks, 0%-20% for High-Risk stocks, and 0%-35% for Speculative stocks); and Sell (3) (negative total return).

For securities in emerging markets (Asia Pacific, Emerging Europe/Middle East/Africa, and Latin America), investment ratings are: Buy (1) (expected total return of 15% or more for Low-Risk stocks, 20% or more for Medium-Risk stocks, 30% or more for High-Risk stocks, and 40% or more for Speculative stocks); Hold (2) (5%-15% for Low-Risk stocks, 10%-20% for Medium-Risk stocks, 15%-30% for High-Risk stocks, and 20%-40% for Speculative stocks); and Sell (3) (5% or less for Low-Risk stocks, 10% or less for Medium-Risk stocks, 15% or less for High-Risk stocks, and 20% or less for Speculative stocks).

Investment ratings are determined by the ranges described above at the time of initiation of coverage, a change in investment and/or risk rating, or a change in target price (subject to limited management discretion). At other times, the expected total returns may fall outside of these ranges because of market price movements and/or other short-term volatility or trading patterns. Such interim deviations from specified ranges will be permitted but will become subject to review by Research Management. Your decision to buy or sell a security should be based upon your personal investment objectives and should be made only after evaluating the stock's expected performance and risk.

OTHER DISCLOSURES

For securities recommended in the Product in which the Firm is not a market maker, the Firm is a liquidity provider in the issuers' financial instruments and may act as principal in connection with such transactions. The Firm is a regular issuer of traded financial instruments linked to securities that may have been recommended in the Product. The Firm regularly trades in the securities of the subject company(ies) discussed in the Product. The Firm may engage in securities transactions in a manner inconsistent with the Product and, with respect to securities covered by the Product, will buy or sell from customers on a principal basis.

Securities recommended, offered, or sold by the Firm: (i) are not insured by the Federal Deposit Insurance Corporation; (ii) are not deposits or other obligations of any insured depository institution (including Citibank); and (iii) are subject to investment risks, including the possible loss of the principal amount invested. Although information has been obtained from and is based upon sources that the Firm believes to be reliable, we do not guarantee its accuracy and it may be incomplete and condensed. Note, however, that the Firm has taken all reasonable steps to determine the accuracy and completeness of the disclosures made in the Important Disclosures section of the Product. In producing Products, members of the Firm's research department may have received assistance from the subject company(ies) referred to in the Product. Any such assistance may have included access to sites owned, leased or otherwise operated or controlled by the issuers and meetings with management, employees or other parties associated with the subject company(ies). Firm policy prohibits research analysts from sending draft research to subject companies. However, it should be presumed that the author of the Product has had discussions with the subject company to ensure factual accuracy prior to publication. All opinions, projections and estimates constitute the judgment of the author as of the date of the Product and are subject to change without notice. Prices and availability of financial instruments also are subject to change without notice. Although Citigroup Investment Research does not set a predetermined frequency for publication, if the Product is a fundamental research report, it is the intention of Citigroup Investment Research to provide research coverage of the/those issuer(s) mentioned therein, including in response to news affecting this issuer, subject to applicable quiet periods and capacity constraints. The Product is for informational purposes only and is not intended as an

offer or solicitation for the purchase or sale of a security. Any decision to purchase securities mentioned in the Product must take into account existing public information on such security or any registered prospectus.

Investing in non-U.S. securities, including ADRs, may entail certain risks. The securities of non-U.S. issuers may not be registered with, nor be subject to the reporting requirements of the U.S. Securities and Exchange Commission. There may be limited information available on foreign securities. Foreign companies are generally not subject to uniform audit and reporting standards, practices and requirements comparable to those in the U.S. Securities of some foreign companies may be less liquid and their prices more volatile than securities of comparable U.S. companies. In addition, exchange rate movements may have an adverse effect on the value of an investment in a foreign stock and its corresponding dividend payment for U.S. investors. Net dividends to ADR investors are estimated, using withholding tax rates conventions, deemed accurate, but investors are urged to consult their tax advisor for exact dividend computations. Investors who have received the Product from the Firm may be prohibited in certain states or other jurisdictions from purchasing securities mentioned in the Product from the Firm. Please ask your Financial Consultant for additional details. Citigroup Global Markets Inc. takes responsibility for the Product in the United States. Any orders by non-US investors resulting from the information contained in the Product may be placed only through Citigroup Global Markets Inc.

The Citigroup legal entity that takes responsibility for the production of the Product is the legal entity which the first named author is employed by. The Product is made available in Australia to wholesale clients through Citigroup Global Markets Australia Pty Ltd. (ABN 64 003 114 832 and AFSL No. 240992) and to retail clients through Citigroup Wealth Advisors Pty Ltd. (ABN 19 009 145 555 and AFSL No. 240813), Participants of the ASX Group and regulated by the Australian Securities & Investments Commission. Citigroup Centre, 2 Park Street, Sydney, NSW 2000. If the Product is being made available in certain provinces of Canada by Citigroup Global Markets (Canada) Inc. ("CGM Canada"), CGM Canada has approved the Product. Citigroup Place, 123 Front Street West, Suite 1100, Toronto, Ontario M5J 2M3. The Product may not be distributed to private clients in Germany. The Product is distributed in Germany by Citigroup Global Markets Deutschland AG & Co. KGaA, which is regulated by Bundesanstalt fuer Finanzdienstleistungsaufsicht (BaFin). Frankfurt am Main, Reuterweg 16, 60323 Frankfurt am Main. If the Product is made available in Hong Kong by, or on behalf of, Citigroup Global Markets Asia Ltd., it is attributable to Citigroup Global Markets Asia Ltd., Citibank Tower, Citibank Plaza, 3 Garden Road, Hong Kong. Citigroup Global Markets Asia Ltd. is regulated by Hong Kong Securities and Futures Commission. If the Product is made available in Hong Kong by The Citigroup Private Bank to its clients, it is attributable to Citibank N.A., Citibank Tower, Citibank Plaza, 3 Garden Road, Hong Kong. The Citigroup Private Bank and Citibank N.A. is regulated by the Hong Kong Monetary Authority. The Product is made available in India by Citigroup Global Markets India Private Limited, which is regulated by Securities and Exchange Board of India. Bakhtawar, Nariman Point, Mumbai 400-021. If the Product was prepared by Citigroup Investment Research and distributed in Japan by Nikko Citigroup Ltd., it is being so distributed under license. Nikko Citigroup Limited is regulated by Financial Services Agency, Securities and Exchange Surveillance Commission, Japan Securities Dealers Association, Tokyo Stock Exchange and Osaka Securities Exchange. Akasaka Park Building, 2-20, Akasaka 5-chome, Minato-ku, Tokyo 107-6122. The Product is made available in Korea by Citigroup Global Markets Korea Securities Ltd., which is regulated by Financial Supervisory Commission and the Financial Supervisory Service. Hungkuk Life Insurance Building, 226 Shinmunno 1-GA, Jongno-Gu, Seoul, 110-061. The Product is made available in Malaysia by Citigroup Global Markets Malaysia Sdn Bhd, which is regulated by Malaysia Securities Commission. Menara Citibank, 165 Jalan Ampang, Kuala Lumpur, 50450. The Product is made available in Mexico by Acciones y Valores Banamex, S.A. De C. V., Casa de Bolsa, which is regulated by Comision Nacional Bancaria y de Valores. Reforma 398, Col. Juarez, 06600 Mexico, D.F. In New Zealand the Product is made available through Citigroup Global Markets New Zealand Ltd., a Participant of the New Zealand Exchange Limited and regulated by the New Zealand Securities Commission. Level 19, Mobile on the Park, 157 lambton Quay, Wellington. The Product is made available in Poland by Dom Maklerski Banku Handlowego SA an indirect subsidiary of Citigroup Inc., which is regulated by Komisja Papierów Wartosciowych i Gield. Bank Handlowy w Warszawie S.A. ul. Senatorska 16, 00-923 Warszawa. The Product is made available in the Russian Federation through ZAO Citibank, which is licensed to carry out banking activities in the Russian Federation in accordance with the general banking license issued by the Central Bank of the Russian Federation and brokerage activities in accordance with the license issued by the Federal Service for Financial Markets. Neither the Product nor any information contained in the Product shall be considered as advertising the securities mentioned in this report within the territory of the Russian Federation or outside the Russian Federation. The Product does not constitute an appraisal within the meaning of the Federal Law of the Russian Federation of 29 July 1998 No. 135-FZ (as amended) On Appraisal Activities in the Russian Federation. 8-10 Gasheka Street, 125047 Moscow. The Product is made available in Singapore through Citigroup Global Markets Singapore Pte. Ltd., a Capital Markets Services Licence holder, and regulated by Monetary Authority of Singapore. 1 Temasek Avenue, #39-02 Millenia Tower, Singapore 039192. Citigroup Global Markets (Pty) Ltd. is incorporated in the Republic of South Africa (company registration number 2000/025866/07) and its registered office is at 145 West Street, Sandton, 2196, Saxonwold. Citigroup Global Markets (Pty) Ltd. is regulated by JSE Securities Exchange South Africa, South African Reserve Bank and the Financial Services Board. The investments and services contained herein are not available to private customers in South Africa. The Product is made available in Taiwan through Citigroup Global Markets Inc. (Taipei Branch), which is regulated by Securities & Futures Bureau. No portion of the report may be reproduced or quoted in Taiwan by the press or any other person. No. 8 Manhattan Building, Hsin Yi Road, Section 5, Taipei 100, Taiwan. The Product is made available in Thailand through Citicorp Securities (Thailand) Ltd., which is regulated by the Securities and Exchange Commission of Thailand. 18/F, 22/F and 29/F, 82 North Sathorn Road, Silom, Bangrak, Bangkok 10500, Thailand. The Product is made available in United Kingdom by Citigroup Global Markets Limited, which is authorised and regulated by Financial Services Authority. This material may relate to investments or services of a person outside of the UK or to other matters which are not regulated by the FSA and further details as to where this may be the case are available upon request in respect of this material. Citigroup Centre, Canada Square, Canary Wharf, London, E14 5LB. The Product is made available in United States by Citigroup Global Markets Inc, which is regulated by NASD, NYSE and the US Securities and Exchange Commission. 388 Greenwich Street, New York, NY 10013. Unless specified to the contrary, within EU Member States, the Product is made available by Citigroup Global Markets Limited, which is regulated by Financial Services Authority. Many European regulators require that a firm must establish, implement and make available a policy for managing conflicts of interest arising as a result of publication or distribution of investment research. The policy applicable to Citigroup Investment Research's Products can be found at www.citigroupgeo.com. Compensation of equity research analysts is determined by equity research management and Citigroup's senior management and is not linked to specific transactions or recommendations. The Product may have been distributed simultaneously, in multiple formats, to the Firm's worldwide institutional and retail customers. The Product is not to be construed as providing investment services in any jurisdiction where the provision of such services would be illegal. Subject to the nature and contents of the Product, the investments described therein are subject to fluctuations in price and/or value and investors may get back less than originally invested. Certain high-volatility investments can be subject to

sudden and large falls in value that could equal or exceed the amount invested. Certain investments contained in the Product may have tax implications for private customers whereby levels and basis of taxation may be subject to change. If in doubt, investors should seek advice from a tax adviser. Advice in the Product has been prepared without taking account of the objectives, financial situation or needs of any particular investor. Accordingly, investors should, before acting on the advice, consider the appropriateness of the advice, having regard to their objectives, financial situation and needs.

ADDITIONAL INFORMATION IS AVAILABLE UPON REQUEST US06R027