

P • U • L • S • E

Dashboard for Health Plan Financial Management

June 2008

Sherlock Expense Evaluation Status Report.

Sherlock Company is in its eleventh consecutive year of performance benchmarking. In 2008, we have 46 plans so far participating in universes of Blue Cross Blue Shield Plans, Larger Plans, Independent (Provider-Sponsored) Plans, Medicare Advantage Plans and Medicaid Plans. *Page 2.*

Private Health Plan Results Reinforce Public Trends.

Recent results from non-public health plans reinforce trends among publicly traded firms. For the trailing three months ended February 28th, 2008, the eleven health plans in our *Health Plan Dashboard* reported revenue growth of 9.3%, with ASO/ASC growth of 63.0% and Medicaid growth of 13.9%, while managed care revenue increased by 0.8%. *Page 3.*

Electronic Data Systems to be Acquired by Hewlett-Packard: Implications for Health Plans.

Electronic Data Systems announced that it had entered into a definitive agreement to be acquired by Hewlett-Packard for approximately \$13.9 billion. *Page 3.*

Capital Cost Comments. Average health plan stocks increased 9.0% for the month of May, outperforming the market. Improving investor sentiment helped and all valuation indicators increased last month. *Page 2.*

Earnings Analysis. Three of the fourteen publicly-traded health plans announced earnings last month. **CIGNA's** net income decreased 24.2%, due in part to declines in non-operating income. **Triple-S Management Corporation** had a 73.9% decrease in net income, causing EPS to decline 77.8% to \$0.04. **Universal American Corporation** experienced an explosive growth in Medicare part D membership to 1.8 million due to its acquisition of Community CCRx (SM) prescription drug plan in September 2007. *Page 6.*

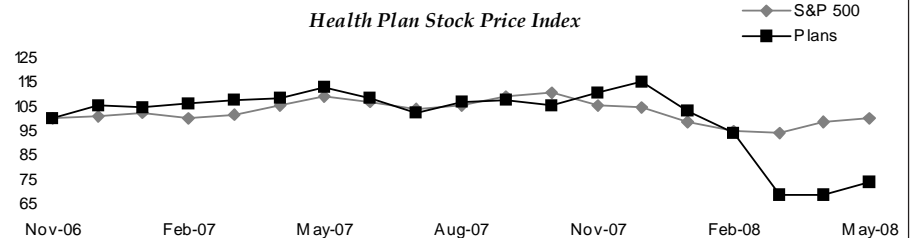
Mergers and Acquisitions. **Humana** completed its \$185 million acquisition of UnitedHealth Group's individual SecureHorizons Medicare Advantage HMO business in Nevada. **Humana** also closed its acquisition of OSF Health Plans, which was announced on March 20th. *Page 7.*

Financing. **Coventry Health Care** received approval to increase its repurchase of shares by an additional 5%. **HealthSpring, Inc.** announced that Herb Fritch, Chairman,

HEALTH PLAN DASHBOARD

Capital Cost Indicators

	Commercial	Medicare	Medicaid	All
Equity Capital Costs				
Price to Sales	0.54	0.44	0.31	0.46
Price per Risk Member	\$2,024	\$6,255	\$867	\$2,319
Price per Total Member	\$1,165	\$6,255	\$862	\$1,806
Price to Operating Earnings	8.3	12.3	9.1	9.1
Price / Earnings	10.8	13.0	13.1	11.8
Price / 2007 Earnings	10.0	11.9	14.3	11.3
Health Plan Industry Beta				0.738
Health Plan Industry Discount Rate				8.57%



Financial / Operational Metrics

	Commercial	Medicare	Medicaid	All
Revenue Growth				
Revenue Growth	13.9%	64.6%	31.0%	26.0%
Price Change	4.9%	24.9%	20.2%	12.1%
Membership Growth	4.3%	16.2%	12.1%	8.2%
Profit Margin				
Operating Margin	4.2%	0.6%	4.1%	3.7%
Health Benefit Ratio	84.2%	88.8%	82.6%	84.4%
Administrative Exp. to Premium	10.0%	11.3%	13.2%	11.1%
Return on Equity	18.5%	9.9%	16.5%	16.7%
Leverage and Solvency				
Debt to Capital	19.1%	15.0%	15.8%	17.6%
Medical Mo. Tang. Book Value	1.90	0.07	1.66	1.57
Days of Claims Payable	87.4	83.5	49.7	76.1
Chg. Days of Claims Payable	(1.7)	(45.1)	(2.2)	(8.0)

President, and Chief Executive Officer, and Kevin McNamara, Executive Vice President and Chief Financial Officer, have adopted a Rule 10b5-1 plan. *Page 7.*

Personnel Changes. **Capital District Physicians' Health Plan** announced that John D. Bennett Jr. is the new President and Chief Executive Officer. **Centene Corporation** has appointed Jesse N. Hunter as Executive Vice President, Corporate Development. **Harvard Pilgrim Health Care** recently announced that James M. DuCharme has been appointed as Chief Financial Officer. *Page 8.*

Insert. **BLUES**, our bi-annual review of the financial performance of Blue Cross Blue Shield Plans. Performance was soft due to decreasing margins. Higher health benefit ratios and administrative expense to premium ratios were evident.

SHERLOCK

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Capital Costs Comments...

Health plan industry stock prices grew 9.0% on average during the month of May. Industry capitalization gained 6.7% for the month. The broader market, measured by the S&P 500, grew by 1.1% last month. Among companies in our universe, the Medicaid plans performed the best, followed by the Medicare plans and then the commercial plans.

Stock prices for thirteen of the fourteen health plans increased last month, led by WellCare, which gained 26.0% on the rumors circulating that it is seeking a buyer. Molina increased 21.5%, followed by Centene's gain of 14.9%. WellPoint and HealthSpring experienced growth of 12.2% and 10.3%, respectively. CIGNA Corporation was the only plan whose stock price declined, by 4.9%.

Only three of the fourteen plans reported earnings last month, of which all saw decreases in earnings. Therefore, it is reasonable to assume the 9.0% increase in stock price was driven by improving investor sentiment of the industry.

Valuation indicators were positive for the month of May. Price to Trailing Twelve Months Earnings increased 12.5%. Price to Estimated 2008 Earnings grew 10.8%. Price to Operating Income increased 20.9%, while Price to Sales grew 11.8%. Price per Risk Member and Price per Total Member were up 12.1% and 13.5%, respectively. The health plan industry beta was 0.738 and the industry discount rate was 8.57%. All rates of change are calculated holding the universe of companies constant.

SHERLOCK EXPENSE EVALUATION STATUS REPORT

Participation Growth

This is our eleventh consecutive year of performance benchmarking, collectively comprising more than 340 health plan years of data. In 2008, we have 46 plans so far participating in universes of Blue Cross Blue Shield Plans, Independent/Provider-Sponsored Plans, Medicare Advantage Plans and Medicaid Plans. Collectively, our participants insure approximately 36 million Americans with comprehensive health benefit plans. Our participants also provide specialty care such as stand-alone dental and Medicare Part D to people not served through the comprehensive products.

Overall, the number plans participating in 2008 are approximately the same as participated in 2007. However, this is approximately 10% greater than at this time last year, and excludes additional Medicare Advantage and Medicaid focused plans that are unable to consider participation pending their submission of the Medicare Advantage bid on June 2nd. In our Blue Cross Blue Shield and Independent/Provider-Sponsored universes more than 90% of last year's participants are participating again. Figure 1 shows the expected dates of availability for each of our peer groups. Dates refer to financial metrics - operational metrics will be released somewhat later.

Enhanced Metrics

Operational metrics in all functional areas have been strengthened, especially in information systems and marketing. There were also some modest changes in segmenting costs by functional area but, as there are up to 52 identifiable functions, granularity may be approaching the optimality between effort and insight. The breadth of our participation in various universes leads to a "cross fertilization" of insights between the plans in the measurement of health plan performance. Building on our past report, our analyses identify the relative performance of variances to the plan, show what functional areas are responsible for variances, and identify the plan's performance characteristics that may contribute to particular variances.

Enhanced Quality Assurance

This year's edition contains new procedures to increase the reliability of the submitted data and the resulting reports. We have strengthened the *Guidelines* (our guidelines for participants to report data and users to compare with their own numbers), which now total approximately 250 pages of definitions, activity descriptions, cost centers, operational outputs and ratio calculation notes. These *Guidelines* are searchable by the users, enhancing the likelihood of compliance. Emerging issues are resolved through an on-line Forum in which all plans participate. Using statistical methods, we have also enhanced our ability to identify responses to our survey that appear to vary from the actual economics of the plans, and we have improved communica-

Figure 1. PULSE
Sherlock Expense Evaluation Status Report

<i>Universe / Edition</i>	<i>Participants</i>	<i>Median Membership</i>	<i>Availability</i>
Blue Cross Blue Shield	23	751,853	Week of June 30th
Provider-Sponsored (Independent)	13	252,699	Week of July 14th
Medicaid-Oriented Plans	8	109,900	Week of September 1st
Medicare Advantage Plans	8	109,556	Week of September 1st
Larger Plans	6	2,758,179	Week of June 30th

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SEER Status Report: *Continued from Page 2*

tion to the participants concerning what we think may be their incorrect responses. Finally, our longevity has led to a practice effect in the accuracy of submissions. For instance, three-fourths of our Blue Cross Blue Shield plans have participated in our performance benchmarking studies for five or more years.

Performance Improvement

We believe that health plans benefit from their participation in our performance benchmarking studies. While our analysis is encyclopedic in scope, our summary letters target product or functional areas which yield the highest rate of return on management investment.

Use in Process Improvement


After eleven consecutive years of benchmarking studies, many plans are using the *SEER* performance benchmarking studies at the functional area levels as well as at the strategic levels of the organization. In addition, we are establishing relationships with leading consulting firms who assist health plans in the improvements of their business processes.

Organizational Advantages

We continue to operate independently. We do not sell products or services that create conflicts of interest, and we are organized to avoid the "tragedy of the commons." Despite this, we operate at very low costs.

Conclusion

After eleven consecutive years Sherlock Company's performance benchmarks have increased in their value in the management of health plan administrative costs. *SEER* both contributes to operating improvements and is an accurate and unbiased gauge of health plan performance to health plans, firms contemplating business combinations and consultants. Because of the strength of our panel, and our record of reliability, we expect continued growth in participation and other applications. Our business model is sound and also assures users that our analyses are free of bias. To support and increase the use of the benchmarking studies, we are considering a number of other supporting initiatives, ranging from support of consulting relationships to application-oriented seminars.


This is intended to be a brief update. Sherlock Company would welcome the opportunity to provide further information. Please contact us at 215-628-2289 or sherlock@sherlockco.com 

PRIVATE HEALTH PLAN RESULTS REINFORCE PUBLIC TRENDS

Recent results from non-public health plans reinforce trends among publicly traded firms. The following results are for the trailing three months ended March 31st, 2008, compared to the same period last year. The eleven health plans in our *Health Plan Dashboard* reported revenue growth of 9.1%, with indemnity growth of 52.0%, ASO/ ASC growth of 29.3% and Medicare Advantage growth of 16.1%, while managed care revenue decreased by 0.7%. Membership declined by 8.1% for managed care but increased by 73.3% in the indemnity business. Managed care and ASO had price increases of 8.6% and 24.6%, respectively, while Medicare Advantage posted an increase of 7.6%.

Health benefits ratios overall grew by 2.1 percentage points, but increased by 7.7% for ASO/ASC line and grew by 5.6 percentage points for indemnity. The number of scripts per person increased by 0.7 to 10.5 on an annualized basis. E/R visits per thousand members increased by 18.7 to an annual rate of 307.5 per thousand and hospital days increased by 2.0 days to 345.3 days per thousand.

The administrative expense to premium ratio decreased by 0.3% percentage points to 8.9%. Claims volumes increased by 0.7 to 15.0 per member per year while inquiries per member remained relatively unchanged at 1.9 per member per year. Staffing ratios increased by 0.98 FTEs to 18.5.

Health plans in our Dashboard universe are comprised of a mix of Blue Cross Blue Shield and Independent/Provider-Sponsored Plans. 

ELECTRONIC DATA SYSTEMS TO BE ACQUIRED BY HEWLETT-PACKARD: IMPLICATIONS FOR HEALTH PLANS

Electronic Data Systems (EDS) announced on May 13th that it had entered into a definitive agreement to be acquired by Hewlett-Packard (HP). We don't normally perform financial analyses of firms that are outside of the health plan sphere but the pending acquisition by Hewlett Packard of EDS is exceptional in its implications for health plan payers. For HP, this transaction will sharply increase its presence in business process outsourcing, and its service to health care payors. It is notable in that it, like Trizetto, another leading provider of health plan transaction processing, is undergoing restructuring.

The Transaction

According to the press release, EDS shareholders will receive \$25.00 per share of stock in cash. The enterprise consider-

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Hewlett-Packard: *Continued from Page 3*

ation of the transaction is approximately \$13.9 billion. The transaction, subject to domestic and foreign regulatory approval and EDS's shareholders, is expected to close during the second half of the 2008. The acquisition is to be financed with cash on hand and the issuance of debt.

HP anticipates that the transaction will increase its 2010 GAAP earnings. By acquiring EDS, HP's services businesses will expand to more than 80 countries, double its service annual revenue to \$38.0 billion and increase its employees to 210,000. The acquisition has benefits for EDS. According to Bob Brand, Director, Corporate Public Relations for EDS Global Communications, the acquisition allows EDS to gain "HP's tremendous resources, including its \$3.6 billion research and development budget and innovative technologies while still retaining its own brand."

EDS will be branded as a HP company and become a new business group, while its offices will remain in Plano Texas. Ron Rittenmeyer, EDS Chairman, President and Chief Executive Officer, will continue to lead EDS and report to HP's chairman and chief executive officer, Mark Hurd. Rittenmeyer will also join HP's executive council.

The Companies

HP was founded in 1939 and is headquartered in Palo Alto California. HP is among the world's largest IT companies. The company operates three divisions: The Personal Systems Group, The Imaging and Printing Group and The Technology Solutions Group.

EDS, based in Plano, Texas, is a global technology company that delivers a portfolio of information technology and business process outsourcing services. EDS serves the manufacturing, financial services, healthcare, communications, energy, transportation, and consumer and retail industries and to governments worldwide.

Hewlett Packard is considerably larger than EDS. It had \$104.3 billion in revenues in its fiscal year ended October 31, 2007 versus \$22.1 billion for EDS in its fiscal year ended December 31, 2007. EDS is much more focused on services although its BPO operations \$3.1 billion are smaller than \$4.8 billion of HP.

Their product mixes are quite different. HP's outsourcing comprised only 4.6% of revenues in 2007. All of services comprised 16.0% of revenues in that year. Interestingly, outsourcing is an increasing proportion of HP's services, increasing from 26.4% in 2005 to 29.0% in 2007. EDS's business was approximately 96.0% of its total.

EDS is heavily committed to health plans. It claims service to 19 million Medicaid recipients, processed 35% of all Medicare and Medicaid claims and serves more than 250 health

care clients with 124 million people in 20 countries. By contrast, HP's web site lists few significant health plan clients. As HP's Chairman, President and CEO, Mark Hurd noted in a conference call with analysts, "When you looked at the portfolio and the customer base and you aligned it with HP's, there was very little overlap."

EDS does not disclose the proportion of its business that is health care, however it notes that of its 140,000 employees, 6,000 are healthcare information technology experts. So while they are a major factor in service to the health care industry, the health care industry includes only 4% of its employees. In addition, approximately one-third of EDS's employees serve U.S.-based government accounts and are accordingly not offshoreable. Notably, GM represents the biggest single account receivable for EDS but its employee health care is only a portion of that.

Synergies

HP has plans for improving the efficiency of EDS. Hurd said that there are "substantial cost synergies from a combined organization." HP has not been specific about them at this point, but Hurd notes significant opportunities for leveraging IT costs, real estate costs and "a \$4 billion R&D stream and a research stream from HP labs."

HP has agreed to pay a roughly one-third premium over EDS's closing price a few days before the announcement, implying confidence in its ability to recognize synergies. These appear to be mainly cost savings. As Hurd states "We did not bake in a lot of revenue synergies. They do exist, but our comments regarding deal accretion are largely based on the cost synergies that we have described. So think of us trying very hard to run the playbook that we think we know how to run very well and giving this business the asset of getting the leverage, the scale of HP."

Others including Richard Gardner, analyst with Citigroup, also believe that EDS's margins have room for improvement. Gardner observed that EDS's are one-half of those of IBM. A comparison of HP's and EDS's financials are not entirely transparent to us on this point. HP's services segment posted an 11.0% operating profit margin in its most recent fiscal year compared with a substantially identical 10.7% for EDS in its most recent fiscal year. But services comprised 95.9% of EDS revenue and on a consolidated basis it reported a consolidated operating profit margin of 5.1%. Moreover, HP reported a consolidated operating profit margin of 8.4%. So perhaps HP is anticipating a margin improvement of up to 3.3 percentage points.

One hint to the source of savings is to recall that transaction processing is a capital intensive business. In each of the past three years, EDS's investments in property and equipment exceeded its income, and the primary source of cash was

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and a price to sales ratio of 0.61 and price to EBITDA of 4.9

Figure 2. PULSE
Valuation and Projected Results for EDS
Dollars in Millions

	Valuation Ratio	Projected 2008	Actual 2007	Pct. Chg.
Revenue	0.61	\$22,787	\$21,909	4.0%
Op. Exp. Before Depr. & Amort.		19,950	19,561	2.0%
EBITDA	4.9	\$2,837	\$2,348	20.8%
Margin		12.4%	10.7%	

times. The emphasis on EBITDA in a capital intensive business such as this makes most sense if neither depreciation and amortization or capital expenditures are to continue in their historic pattern. Please see Figure 2 for the model for 2008 that is implied from HP management's valuation ratios.

Figure 3. PULSE
Feasibility of EDS Projections
Dollars in Millions, Excludes Verizon Payment

Years Ended December 31	2007 a	2008 p	Pct. Chg.	Change
Operating Income	\$907	NA		
Depreciation	1,441	NA		
EBITDA	\$2,348	\$2,837	20.8%	\$489
<i>Quarter Ended March 31</i>	<i>2007 a</i>	<i>2008 a</i>	<i>Pct. Chg.</i>	<i>Change</i>
Operating Income	\$40	\$97	142.5%	57.00
Depreciation	330	383	16.1%	53.00
EBITDA	\$370	\$480	29.7%	\$110
<i>Final Three Quarters 2008</i>	<i>2007 a</i>	<i>2008 p</i>	<i>Pct. Chg.</i>	<i>Change</i>
Operating Income	\$867	NA		
Depreciation	1,111	NA		
EBITDA	\$1,978	\$2,357	19.1%	\$379

The 2008 goals seem feasible for EDS. Excluding the effect of a \$225 million payment to EDS in connection with the end of a Verizon contract, EBITDA increased by 29.7% in the first quarter of 2008. For the last nine months of 2008, EBITDA has to increase by 19.1% to achieve stated HP's objectives for 2008. We have not modeled 2009 and future years in which HP will be

depreciation and amortization and deferred cost charges. HP's investment was a much smaller proportion of its net income and accordingly its 2007 fixed asset turnover was 3.10 versus 2.55 for EDS.

Thus, one way of conceptualizing the transaction is that EDS is being acquired to provide a distribution system to leverage HP's existing investments. As Hurd puts it, "Frankly, EDS is more mature and more sophisticated in many of the processes that they bring to market than where we are. So frankly, it is almost us putting our outsourcing business into EDS, giving our outsourcing business the leverage of that capability and scale and maturity."

We believe that the combined businesses are intended to leverage HP's investments (in other words, eliminate duplication of them) to improve combined cash flow. This seems implied in the sources of savings and also the focus of the valuation metrics. HP believes that it is purchasing a company that will have revenues of \$22.3 billion and EBITDA of \$2.8 billion, based on enterprise valuation of \$13.9 billion

able to fully integrate the organization.

Conclusion

If HP and EDS are able to realize their anticipated synergies, the combined companies should be more profitable as a result. More significantly, they will achieve their better improvements by reducing their combined capital investments, thereby increasing cash flows. From the standpoint of their combined customer base, this could lead to lower costs to health plans, though the fact that there are fewer competitors could conceivably mute this effect.

Earnings Analysis...

CIGNA Corporation had a 5.8% growth in total membership to 9.8 million for the first quarter of 2008. Total revenues increased 1.9% to \$3.1 billion.

Risk membership declined 6.8% to 1.5 million members. (When calculating risk membership, Voluntary/Limited Benefits and Experience Rated membership were adjusted by the proportion of their PMPM revenues to Commercial HMO revenues PMPM). Total health care segment revenues decreased 0.9%, to \$2.2 billion.

Membership in CIGNA's commercial HMO product declined 38.7% to 411,000, while monthly premiums increased 2.0% to \$320.36. Revenues for this product declined 37.4% to \$395 million. Other Guaranteed Cost membership grew 16.6% to 534,000. Premiums PMPM increased 14.1% to \$308.99. Revenues grew 33.1% to \$495.0 million.

Medicare membership increased 3.1% to 33,000 members, but monthly premiums increased 4.7% to \$959.60 PMPM. Therefore, Medicare revenues grew 8.0% to \$95.0 million. CIGNA's Medicare Part D had a 30.1% increase in membership to 333,000, while premiums PMPM declined 15.8% to \$103.10. Revenues for this product grew 9.6% to \$103.0 million.

The estimated total health benefits ratio grew 0.5 percentage points to 83.8%. The estimated administrative expense ratio decreased 0.2 percentage points to 6.3%. (This is our calculation and we do not have strong confidence in its comparability with other firms.) Operating income for the company declined 19.4% to \$166.0 million, as the operating margin decreased 1.4 percentage points to 5.4%.

Non-operating income decreased 29.5% to \$146.0 million primarily due to the net investment income for the health care segment decreasing 13.0% from lower investment yields and a loss in CIGNA's run-off reinsurance segment. Net income decreased 24.2% to \$210.0 million. The net margin declined 2.4 percentage points to 6.9%. EPS decreased 20.5% to \$0.73, as the number of shares outstanding declined 4.7% to 282.5 million.

Triple-S Management Corporation, in the first quarter of 2008, saw total membership increase 1.0 % to 985,281 members. Total revenues for the managed care portion of the company increased 17.6% to \$364.5 million, primarily due to a product mix shift in favor of its Medicare Advantage product. Triple-S is a publicly traded Blue Cross Blue Shield Plan, based in Puerto Rico.

Fully-Insured membership declined 1.3% to 412,692 in the first quarter. Fully-insured premiums PMPM increased 2.3%

to \$147.00, as fully-insured premiums increased 0.9% to \$182.0 million.

Reform membership decreased 2.8% to 343,534 members. Premiums PMPM for the Reform product increased 16.1% to \$78.59. These factors decreased Reform premiums by 12.8% to \$81.0 million.

The combined premiums for Medicare (Advantage and Part D) increased 81.1% to \$96.9 million. (The company does not segment premiums and membership for Stand-Alone Medicare Part D from Medicare Advantage.) Membership in Medicare increased 54.7% 65,638 members. According to Kathy Waller, Co-President of Financial Relations Board, "One of the big growth opportunities for Triple-S is the Medicare Advantage business and they are consciously trying to grow the business."

ASO membership increased 1.2% to 163,517 in the first quarter. ASO fees PMPM increased 3.3% to \$9.38, as ASO premiums increased 4.5% to \$4.6 million.

The company's health benefits ratio increased 1.1 percentage points to 90.0% for the first quarter of 2008, while the administrative expense ratio declined 1.2 percentage points to 10.1%. The operating margin grew 0.1 percentage points to (0.1%), as operating income decreased 57.2% to (\$307.0) million.

Non-operating income decreased 86.8% to \$778,000, as a result of a 544.0% decrease in the non-health segments of the company. Pre-tax income for the non-health segments of the company decreased due to increased operating costs and the net unrealized losses on trading securities increased. Net income decreased 73.3% to \$1.2 million. EPS for the quarter were \$0.04, which was a 77.8% decrease over the same period in 2007.

Universal American Corporation increased total membership in its Medicare Advantage and PFFS products by 18.9% to 228,105 members in the first quarter of 2008 from 191,770 for the comparable quarter of 2007. The primary reason for this increase in membership is due to the growth in its Private Fee-for Service business. As of the end of the fourth quarter 2007, PFFS members comprised 77.1% of Universal American's members and the remaining 22.9% of members were Medicare Advantage HMO. Total premiums rose 78.3% to \$1.4 billion.

Membership in its Medicare Advantage product increased 14.3% to 52,143 members. Medicare Advantage HMO premiums PMPM increased 12.3% to \$1,008.11. Premiums for Medicare Advantage HMO increased 28.4% to \$157.7 million from \$122.8 million for the comparable quarter last year.

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Earnings Analysis: Continued from Page 6

Medicare PFFS product grew 20.4% to 175,962 members while its premiums PMPM increased 27.9% to \$775.93. Revenues for Medicare PFFS increased 54.0% to \$409.6 million.

Stand-Alone Medicare Part D had an increase of 270.7% in membership to 1.8 million. Monthly premiums for the stand-alone Medicare Part D decreased 4.3% to \$117.34 PMPM. Stand-alone Medicare Part D revenues grew 254.9% to \$639.9 million. This explosive growth in Universal American's stand-alone Medicare Part D product is due to its acquisition in September 2007 of Community CCRx (SM) prescription drug plan which had approximately 1.3 million members.

The company's health benefits ratio increased 4.4 percentage points to 93.6% for the first quarter of 2008, while the administrative expense ratio decreased 2.2 percentage points to 9.2%. Operating income declined from (\$5.3) million to (\$40.7) million, as the operating margin decreased 2.1 percentage points to (2.1%).

Net income, excluding the extraordinary item of a net realized loss of \$29.3 million, dropped from \$13.7 million to (\$8.4) million, while net margin decreased 2.2 percentage points to (0.6%). The "net realized loss of \$29.3 million is from additional impairments on its subprime mortgage portfolio," according to the press release. EPS before the extraordinary item declined 140.2%, from \$0.23 to (\$0.09), as shares outstanding increased 52.1% to 92.2 million in the first quarter.

Mergers and Acquisitions...

Humana announced on May 1st that it has completed the \$185 million acquisition of the UnitedHealth Group's individual SecureHorizons Medicare Advantage HMO business in Nevada, announced in February. The transaction received final approval from the Centers for Medicare and Medicaid Services, the Nevada Division of Insurance and the Kentucky Office of Insurance. This acquisition is a condition of the approval from the U.S. Department of Justice for the merger between UnitedHealth Group and Sierra Health Services. UnitedHealth Group had to divest its contracts and assets associated with individual SecureHorizons Medicare Advantage HMO plan in Clark and Nye counties in Nevada.

The acquisition of individual SecureHorizons Medicare Advantage HMO will increase Humana's Medicare Advantage HMO membership by 26,700. Humana's Medicare Advantage HMO membership was 465,600 as of March 31, 2008. Published in March 2008 edition of *PULSE* are valuation statistics for the acquisition of individual SecureHorizons Medicare Advantage HMO. Humana does

not expect this acquisition will significantly impact its 2008 EPS estimates.

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Humana closed its acquisition of OSF Health Plans, announced on March 20th. Humana paid OSF Saint Francis, Inc. \$90.5 million in cash to acquire OSF Health Plans, Inc., the Peoria, Illinois-based licensed managed care company. OSF Health Plans has 78,000 members, of which 14,000 members are served through its Medicare Advantage business. Humana does not expect this acquisition to have any effect on its 2008 EPS estimates. In the April 2008 edition of *PULSE*, valuation statistics for the OSF Health Plan acquisition are published.

Financing...

Coventry Health Care received authorization from its board of directors to increase its repurchase of shares by an additional 5%. This will bring its total authorization to approximately 9.9 million shares. The repurchased shares could be 6.4% of the total. At current market price as of May 30th, the share repurchase will reduce cash by \$455.7 million and equity by 13.9%. As of March 31, 2008, Coventry had approximately 154.2 million shares outstanding. The shares will be able to be purchased in the open market, block purchase or in privately-negotiated transactions.

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HealthSpring, Inc. announced recently that Herb Fritch, Chairman, President, and Chief Executive Officer, and Kevin McNamara, Executive Vice President and Chief Financial Officer, have adopted a Rule 10b5-1 plan.

Approximately 1.0 million shares are covered in Fritch's plan. Up to 500,000 shares are subject to prepaid forward-sale contract. Fritch will continue to have rights to voting, dividends, and future stock appreciation under the forward-sale contract until December 2009, in which is the expiration of the contract. The plan also includes the sale of up to 500,000 shares between August 18, 2008 and June 16, 2009.

McNamara's plan includes the sale of 270,000 shares made over a one-year period, beginning no earlier than June 16, 2008. Rule 10b5-1 of the Securities and Exchange Act of 1934 allows officers and directors of firms to adopt plans to sell specific amounts of stock in order to diversify investments, assuming that the officers do not hold material nonpublic information.

Personnel Changes...

Capital District Physicians' Health Plan announced that **John D. Bennett Jr.** is the new President and Chief Executive Officer. For the past five years, he was the chairman of the board for CDPHP. Bennett will begin his duties as CEO on July 1st. He practices cardiology with Albany Associates in Cardiology, a division of Prime Care Physicians PLLC, and is the chief of cardiology at Albany Memorial Hospital. He also served as the interim chief executive of Prime Care beginning in November. Bennett will give up his practice and duties at Prime Care when he begins at CDPHP.

Centene Corporation appointed **Jesse N. Hunter** as Executive Vice President, Corporate Development beginning April 22, 2008. Hunter will direct business opportunities and report directly to Michael F. Neidorff, Chairman and Chief Execu-

tive Officer. He has been with Centene for 6 years and has been the Senior Vice President, Corporate Development. Previously, Hunter worked at Humana, Inc. in its mergers and acquisitions department. He earned his undergraduate degree in Finance from Miami University in Ohio and his M.B.A. from Washington University in St. Louis.

Harvard Pilgrim Health Care recently announced that **James M. DuCharme** has been appointed as Chief Financial Officer. His record of accomplishments included serving as the CFO and Senior Vice President of Finance for Capital District Physicians' Health Plan, and as the CFO, Vice President of Finance and Treasurer of Blue Cross & Blue Shield of Vermont. He is responsible for Harvard Pilgrim's financial, actuarial and underwriting functions.

Analysts' Earnings Estimates

Consensus estimates are the average of brokerage house estimates that are reported to us. Firms contributing to the consensus estimates have an analyst who has expertise in the health plan industry.

Contributing firms are **Citi Investment Research, Deutsche Bank, Lehman Brothers, Morgan Stanley, Oppenheimer & Co. Inc. and Wachovia Capital Markets.**

No representations are made by Sherlock Company or the polled brokerage firms as to the likelihood of the occurrence of the projected EPS estimates or the accuracy or completeness of the information required to interpret these estimates. It should be understood that the actual EPS may not necessarily occur based on the projections here enclosed. Indeed, it is probable that the EPS will not occur as projected here and the magnitude of the differences between the projections and the ultimate results cannot be reliably estimated. Also, some of the consensus estimates are based on only one analyst's estimate.

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