



Understanding Private-Sector Medicare

A primer for investors

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The Medicare Program

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The Medicare Program

Administered by the Centers for Medicare and Medicaid Services (CMS), under the Department for Health and Human Services

Restructured significantly via the Medicare Modernization Act of 2003

Includes four major components:

Part A – helps pay for inpatient hospital services, skilled nursing facility services, certain home health services, and hospice care

Part B – helps pay for doctor services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies

Part C – offers Medicare beneficiaries an array of private health plan options (HMOs, PPOs, and Private Fee-for-Service plans) as an alternative to original Medicare; may also include Part D benefits

Part D – coverage for prescription drugs only

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Types of Private-Sector Medicare Coverage

Medicare Advantage

Health Maintenance Organization (HMO)

Preferred Provider Organization (PPO)

Private Fee-for-Service (PFFS) – Available in limited geographies only

Part D - Prescription Drug Plan (PDP)

Medicare Advantage plus Drugs (MA-PD)

HMO

PPO

PFFS – Available in limited geographies only

Medicare Supplement (Medigap)

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Overview of Medicare Advantage

Provides Medicare beneficiaries with private health plan options (local HMOs, local PPOs, regional PPOs, and limited areas with PFFS plans) as alternatives to original Medicare under Part C of the program

Medicare Advantage participants generally receive benefits in excess of those available under original Medicare, typically including reduced cost sharing, prescription drug benefits, care coordination, techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, disease management programs, and wellness and prevention programs

Medicare Advantage plans may include a Part D benefit (MA-PD)

Involves annual enrollment period, October 15 through December 7 beginning in 2011, for 2012 plan year

Involves an annual competitive bidding process

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Humana Medicare Advantage Networks

HMO and PPO plans may eliminate or reduce coinsurance or deductibles on many other medical services while seeking care from participating providers, and/or in emergency situations.

PPO plans carry an out-of-network benefit that is subject to higher member cost sharing.

PFFS plans are available with or without a network and only available in certain areas where there are fewer plan choices for the beneficiary. Network PFFS plans are similar to PPO plans. Non-network PFFS plans have no preferred network; members have the freedom to choose any health care provider that accepts patients at reimbursement rates set by the health plan, which must be at least the same as original Medicare.

All plans may include copayments, coinsurance, and deductibles; benefit designs must provide at a minimum the actuarial equivalent of benefits available under original Medicare.

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Overview of Part D Program

Provides Medicare beneficiaries with prescription drug benefits under Part D of the program

May be offered through MA plans or on a stand-alone basis; offered exclusively through private entities

Involves an annual competitive bidding process

Beneficiaries who have dual-eligibility for Medicare and Medicaid will be auto-assigned into a PDP if not already in an MA plan (dual-eligibles maintain the right to switch between plans or choose a PDP themselves)

Private entities accept most of the related insurance risk but some is offset by risk-sharing corridors and reinsurance subsidies from CMS

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Defined Standard Benefit PDP – 2011

Member			CMS ^(b) Share	Plan Share	
Low-income	Average-income	Share			
First \$310 of annual drug spend			100%	-	-
Next \$2,530 <small>(up to cumulative spend^(a) of \$2,840)</small>			25%	-	75%
Next \$3,607.50 <small>(up to cumulative spend^(a) of \$6,447.50)</small>	Next \$3,643.72 <small>(up to cumulative spend^(a) of \$6,483.72)</small>	93%	-	7% ^(c)	Generics
		100%	-	-	Brand
Remainder of costs			5% ^(d)	80%	15%

Commonly referred to as the 'donut hole'

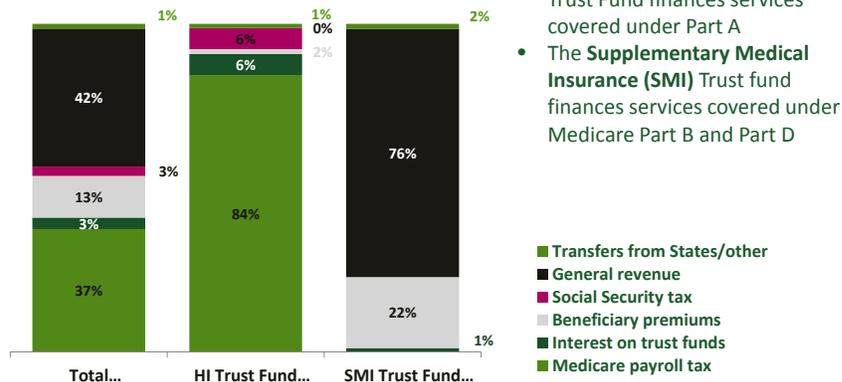
- 'Donut hole' scheduled to be phased-out with following cost share percentages in 2020
 - Generics – member cost share will be 25% and plan cost share will be 75%.
 - Brand name – member cost share will be 25%, plan cost share will be 25% and drug company cost share will be 50%

- a) Total drug costs paid by both the health plan & the member
- b) Through reinsurance subsidies
- c) Standard benefit now includes 7% of CMS defined generics for non-Low-income members
- d) With \$2.25 or \$5.60 minimum, depending upon the drug

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The Two Medicare Trust Funds



- The **Hospital Insurance (HI)** Trust Fund finances services covered under Part A
- The **Supplementary Medical Insurance (SMI)** Trust fund finances services covered under Medicare Part B and Part D

- Transfers from States/other
- General revenue
- Social Security tax
- Beneficiary premiums
- Interest on trust funds
- Medicare payroll tax

Source: 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1

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Payments to Health Plans

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Sources of Medicare Advantage Premium

CMS base premium per member (*specific to the county in which the member resides*)

Beginning in 2012 counties will be segregated into payment quartiles

Individual member risk-adjustments

Member premium paid by the individual member to the health plan

Quality Bonus Payments related to star ratings

Part D risk-share computations (not specific to county) may increase or decrease total premium income

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Medicare Advantage Premiums – Quartiles

Base member premiums are established by county

Beginning in 2012 each county will be in one of four payment quartiles representing base premium as a percent of original Medicare fee-for-service (FFS) rates. There is a transition period to new rates of either two, four, or six years depending current rates for each county.

Quartiles

- 95% for the highest cost counties such as Miami-Dade, Florida
- 100% for counties in quartile 2
- 107.5% for counties in quartile 3
- 115% FFS for counties with the lowest costs in quartile 4

Transition Periods to New Rates

- 2 years – If new quartile results in payment change of less than \$30 per month
- 4 years – If new quartile results in payment change of between \$30 and \$50 per month
- 6 years – If new quartile results in payment change of more than \$50 per month

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Risk-Adjustments

CMS base premiums are risk-adjusted to reflect the health status of the individual member

Coding of individual claims affects risk score of individual member

The risk-adjustment process

- Health care providers submit documentation of member claims and/or encounters to individual health plans for submission to CMS
- Health plans summarize and forward electronic documentation received from providers to CMS
- CMS uses data to calculate risk score and adjusts the individual health plan's standard monthly premium payment based upon the individual member's health status
- Approximately six to nine months into the plan year and again approximately six to nine months subsequent to the close of the plan year, CMS updates risk scores using most recent encounter submissions and makes any necessary adjustments to plan-year premium

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Medicare Advantage Premiums – Quality Star Bonuses

Rated Plans

Quality Rating	Quality Bonus Payments
5 star plans	
2012	5.00%
2013	5.00%
2014	5.00%
4 and 4.5 star plans	
2012	4.00%
2013	4.00%
2014	5.00%
3.5 star plans	
2012	3.50%
2013	3.50%
2014	3.50%
3 star plans	
2012	3.00%
2013	3.00%
2014	3.00%
Less than 3 star plans	
2012	0.00%
2013	0.00%
2014	0.00%

New or Low Enrollment Plans

	Quality Bonus Payments
New plans*	
2012	3.00%
2013	3.00%
2014	3.50%
Low enrollment/small plans	
2012	3.00%

From 2012 through 2014 new plans or those with at least 3 stars will be paid additional quality bonus payments

In 2015, quality bonus payments will revert back to those proposed by the Patient Protection and Affordable Care Act of 2010

* If a company has previously contracted with CMS for other plans, the quality bonus payments for the new plan is equal to the enrollment-weighted rating of all of the company's other rated plans.

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Sources of Payments to PDPs

Payment description	Average-income member	Low-income member ^(a)
Standard premium	CMS pays	N/A
Member premium	Member pays	CMS pays
Risk-share premium	CMS pays	CMS pays
Low-income premium subsidy	N/A	CMS pays
Low-income drug cost ^(b) subsidy	N/A	CMS pays
Reinsurance subsidy ^(b)	CMS pays	CMS pays
Coverage gap payments ^(c)	CMS pays	N/A

a) Low-income member subsidies are graduated. Depending upon member income, member may have partial premium payment.

b) Low-income member drug costs and reinsurance subsidies are considered deposits and therefore affect the balance sheet, but not the income statement.

c) Coverage gap payments for brand name drugs will be reimbursed to CMS by drug companies. These payments are considered deposits and therefore affect the balance sheet, but not the income statement.

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PDP Member Premiums Computation

Projected PDP revenue excluding reinsurance subsidy
Divided by projected risk score used in projected PDP revenue
= Revenue adjusted to standard risk score of 1.00 ^(a)
Less national bid average ^(b)
Plus national base member premium ^(b)
= Member premium included in PDP bid

a) Revenue received will be adjusted to reflect member's actual risk score

b) Amount is estimated in original bid; bids must be re-filed with actual amounts once published by CMS to determine the impact upon the member premium

Annual Bidding Process

Medicare Advantage Annual Bidding Process

Timeframe	Event
First Monday in April	CMS publishes Medicare rate book and bidding instructions for the following year.
April and May	Company actuarial teams evaluate data and benefit plan designs to determine bids.
First Monday in June	Companies submit bids for all MA plans to be offered the following year (separate bids for (1) Parts A & B and (2) integrated Part D).
June and July	CMS reviews bids for adequacy and appropriateness of plan designs.
August	Regional PPO benchmarks are determined by CMS based on both the bids and the Medicare rate book. Regional PPO plans bidding below the PDP benchmark adjust bids to re-allocate 75% of savings to lower premiums or increase benefits for Parts A & B (25% of savings reverts to U.S. Treasury).
September	CMS signs final contracts for upcoming year.

Medicare Advantage Part D Annual Bidding Process

Timeframe	Event
First Monday in April	CMS publishes bidding instructions for the following year.
April and May	Company actuarial teams evaluate data and benefit plan designs to determine bids.
First Monday in June	Companies submit bids for all Part D plans to be offered the following year (each company must submit one bid for the defined standard plan design or its actuarial equivalent).
June and July	CMS reviews bids for adequacy and appropriateness of plan designs.
August	Average of Part D bids for the standard plan (using calculation defined by CMS in April) determines the benchmark. Bids are adjusted to reflect actual benchmarks and the related effect upon member premiums.
September	CMS signs final contracts for upcoming year. Auto-assignment of dual-eligibles for plans below the regional benchmark (to be effective January 1).

Risk Sharing

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Part D Risk-Sharing Corridors

Pharmacy costs PMPM **higher** than the annual bid amount :

5% - 10%: CMS reimburses plan for 50% of excess

> 10%: CMS reimburses plan for 80% of excess

Pharmacy costs PMPM **lower** than the annual bid amount :

5% - 10%: plan reimburses CMS for 50% of savings

> 10%: plan reimburses CMS for 80% of savings

Not included in determining risk-sharing:

Pharmacy costs associated with benefits in excess of the defined standard plan design

Administrative expense overruns or savings

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** Settlements with CMS are approximately nine months after close of plan year*

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Risk-Share Accounting

Computations are done by plan by region and include numerous detailed technical complexities

A year-to-date analysis is performed monthly for the current year and quarterly for the prior year to determine the variance from the annual PMPM bid cost

The risk-share receivable from or payable to CMS is recorded on the balance sheet with the offset to premium revenue

Risk-share assets or liabilities are classified as current if within one year of the anticipated settlement with CMS

Because of the exclusion of many components of income from the risk-share calculation, one can not correlate changes in risk-share receivables or payables to changes in the profitability of the related program for the company

Medicare Acronyms

Medicare Acronyms

CMS – Centers for Medicare and Medicaid Services, the arm of the Department of Health and Human Services that administers the Medicare program

HMO – Health Maintenance Organization

MA-PD – Medicare Advantage plus Drugs

PFFS – Private Fee for Service

PMPM – Per Member Per Month

PPO – Preferred Provider Organization

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Follow-Up Questions

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