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WCG - WELLCARE HEALTH PLANS, INC. AT JPMORGAN GLOBAL HEALTHCARE CONFERENCE

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PRESENTATION

John Rex - *J.P. Morgan - Analyst*

All right, welcome, day two here. I'm John Rex, and I cover managed-care names for J.P. Morgan.

Presenting next is WellCare. WellCare is a government pure play, diversified into both Medicaid and the Medicare business. Alec Cunningham, the CEO, will be making the commentary this morning. Alec.

Alec Cunningham - *WellCare Health Plans, Inc. - CEO*

Great. Thanks very much, John; thanks for the introduction and the opportunity to be here, and thank all of you for your time and interest in WellCare this morning.

Before we get started, I would ask that you read our cautionary statement regarding forward-looking statements. I'm not going to be updating our guidance today. Our guidance is as of November 2, which is the date of our last earnings call.

So in terms of what we do, our focus is on helping our government customers reduce cost and improve health care quality and access for the publicly funded healthcare programs. WellCare, as John said, is focused exclusively on the complementary programs of Medicaid and Medicare.

And within Medicare, our focus is on the lower-income strata, including the duly eligible population that's very complementary to our Medicaid business and our Medicare Part D businesses.

We serve, as you will see in a moment, the full spectrum of eligibility groups in the Medicaid segment, all the way from the low-income women and children in the TANF population, all the way up through the higher-acuity populations of the aged, blind and disabled, the SSI, manage long-term care and nursing home diversion programs. That has enabled us to develop a very robust operating platform and tool kit that helps us manage the duly eligible and be an attractive alternative to our customers who are looking for a managed-care solution for those higher chronic populations.

We have had a successful growth and expansion strategy over the years of entering a new market to pursue an attractive opportunity. And once we have a presence, we have a subsidiary, we have an infrastructure, we have networks, then leveraging those networks to increase our geographic footprint, our product mix or both.

I want to give you a quick overview of each of our product segments, starting with Medicaid, which is the largest. We got into the Medicaid business about 15 years ago in our home state of Florida, and now we have grown to be serving eight states, including five of the 10 largest by Medicaid population. The most recent addition is our Kentucky program, but we have a long track record of success.

And as is illustrated here in the table, as you will see, we do have broad history of serving the full spectrum of populations across multiple geographies, again, from the TANF population, which is the low-income women and children, up through those more chronic populations, the aged, blind and disabled, nursing home diversion.

Moving to our Medicare Advantage segment, we are very pleased with the success that we had in this year's annual election period for Medicare sales. We are seeing about a 10,000-member net growth from December 31 to January 1, and we are operating in 138 counties and 11 states, and that gives us access to approximately 10 million members. So we are well positioned for future growth.

As I mentioned a moment ago, we are focused on that lower-income strata of the Medicare population, including those that are duly eligible for Medicaid and Medicare through our dual special-needs plans. And we grew the dual special needs plans well through 2011, actually grew it by over 50%. And that now comprises about 30% of our overall Medicare Advantage book. And, again, that lower-income tier is very complementary to our Medicaid products, where we have the aged, blind and disabled population, and also our Medicare Part D.

Turning to the Medicare Part D, this is a product that performed well for us through 2011. We receive membership in this product two different ways. There are those who choose us, and there are those who are assigned to us by the government. For the choosers, we think we have done a good job of benefit and product design relative to utilization patterns, a heavy emphasis on generics and cost structure for what is a very value and cost-conscious segment of the population.

And then in terms of auto-assigns, the amount of auto assignment that we get and the geographies where we receive those auto assignees is really the result of each year's bidding process. And this year, as you see on the map, we are below the benchmark, and we will receive auto assignment in five of the CMS regions. And we are within what is known as the de minimis range in 17 more. And what the de minimis means is, while we are not below the benchmark economically from our bids and we will not receive auto assigns this year, we are able to retain the auto assignment that we received last year.

So we have done a good job on the choosers. Over half of the membership that we've got has chosen us. And then again, we are going to be receiving auto assignment in five of the 17 regions.

We ended last year at approximately 975,000 members. Based on the bidding results, we are at about 900,000 for 1/1. We expect a modest decrease in our membership throughout the year; but, that said, this is still a very solid product for us. It's key to our dual strategy, and we are well positioned for the future.

So this is a snapshot of where we are by product and market. Currently, we're serving about 2.5 million members across our different markets and products in 49 of the states, and we are expecting to generate about $6 billion in total revenue for 2011. And we have strong market share presence in each of the big markets and products that we serve.

I want to touch for a moment on our operating model. We think this has been a key to our ability to grow and expand over the years while also making sure that we continue to effectively execute on our existing business. We are headquartered in Tampa, and that's where we manage our shared service platform and operations. That is primarily the high-volume transactions that lend themselves to centralized management and scale efficiency, so things such as customer service, claims adjudication, health service operations.

But in each of our local markets, we have a local market owner, a P&L owner, and we have the majority of what I would describe as the customer-facing functions, regardless of how you define the customer, be it the member, our state regulator and customer or a provider. So local case and disease management and quality management teams, our Medicare Advantage sales force, local/state regulatory affairs, etc.

And that has really allowed us to get the advantage and the predictability of the single operating platform that we manage, while making sure that the unique needs of each of our customers, products and markets is met.

Talking about the future in 2012, so in early 2010, we established three areas of focus that remain our priorities for 2012. The first of those is improving health care quality and access. Second is achieving a competitive cost structure, both in terms of SG&A and medical expenses. And then finally, delivering prudent and profitable growth.

Moving to the first of those priorities, we are very focused on preventive health services and wellness services. We have recently deployed a pilot under which our Medicaid members can receive incentives for timely accessing needed preventive health and wellness services.

We have also recently deployed a new technology in our customer service operation that allows us, while we have somebody on the telephone, to identify care gaps in needed health services. And while we have the folks on the phone, we can educate them about those needed services. We could help, if needed, with physician selection and even facilitate appointment making and other logistical support, if that's what's necessary to make sure that our members get the needed health care services.

In terms of accreditation, we have talked historically about our long-term goal of getting accreditations for all of our health plans. And we have made continued progress on that front. In 2010 we achieved URAC accreditation for both of our Florida operating subsidiaries. In 2011, we achieved NCQA accreditation for our Georgia and Missouri operations. So we continue to make progress and stay focused on that longer-term goal of having accreditation for each of those health plans.

And then in terms of our Medicare business and the federal government's emphasis on the Stars programs, that's a continued area of focus and investment and hard work for us on data and infrastructure, data management, our health care management programs, disease and case management and our member experience. And currently approximately 90% of our Medicare Advantage membership is in plans with a 3-star rating.

Moving onto our cost structure, we have made good progress this year both in terms of administrative and medical expenses. On the SG&A side, year over year 2010 to 2011, we expect to 60 basis point reduction in our adjusted SG&A ratio. And that would include the expenses that we have incurred for the launch of our Kentucky Medicaid program. And we have stayed focused on what is our long-term goal of an adjusted SG&A ratio in the low 10% range based on our product and geographic mix.

And in terms of medical expense management, this remains a very important discipline for us based on the state fiscal situations and the challenging rate outlook. And as you see, year over year our initiatives here and our efforts have contributed to a reduction in the overall company medical benefits ratio. And that is going to remain an area of focus for us.

And then turning to growth, we are delighted to have won and recently launched our new Kentucky Medicaid program. This is our first Medicaid launch in several years, but it has gone very, very well, and the team has done an excellent job. I think many of you know the state had a very aggressive timeline; they wanted to go from contract award to launch in just over 90 days, initially. So all of the build and the testing and the preparation to go live -- the team did a good job, including building a very robust network. As you see, we have over 9,000 providers and 90 hospitals.

We have deployed a field-based case management team. Given that this market includes the full spectrum of eligibility groups that I mentioned a moment ago, from the low-income women and kids with an emphasis on perinatal services and pediatric preventive services, all the way up through the aged, blind and disabled and the chronically mentally ill.

That team has already got over 5,000 individuals in active case management, which, of course, is a key to launching a program like this, given that there isn't a managed care history. So we feel good about that.

We have also, for 1/1, achieved growth. We started the program at about 116,000 members on November 1. The state has a 90-day window during which individuals can choose to change plans, and we have been a beneficiary of some of that choice. And we are seeing growth to approximately 135,000 members for 1/1.

And within that 135,000, we have over 10,000 duals. And that, coupled with over 10,000 Part D lives that we've got in the state, then positions us very well for the future and a subsequent launch of Medicare Advantage-coordinated care products in the state, and, again, our focus on the duly eligible populations.

This is a quick overview of the Medicaid pipeline that we are monitoring. The first two products, Hawaii and Missouri, are active procurements that are underway. Applications or responses have gone in, and contract awards have not yet been made. Kansas is one that is an opportunity that we are evaluating; that's an active procurement now if we choose to pursue that. Then the proposals will go in later in the first quarter of this year. And then Ohio, Georgia and Florida -- we are expecting re-procurements or expansion opportunities in these three states, which are incumbent states for us, in 2012.

And in addition to the fact that we are excited about an opportunity to compete in markets where we have a presence, we have incumbency, we have a proven track record, provider relationships and other things, all three of these have some dimension of an inclusion or an expansion of the aged, blind and disabled populations. So again, that's very complementary to our focus on duals, given that we are already writing Medicare Advantage business in all three of those states in we have an existing presence.

Moving to Medicare and growth, as I said, we feel very, very good about the progress that we made for AEP this year with the net adds of approximately 10,000. We expect continued growth through 2012, as we saw in 2011, really driven by two things. One, as I mentioned, we are offering dual special needs plans in 100% of the counties that we serve. And, given that the dually eligible population can choose a plan any month, they are not constrained by the annual election period that exists each fall, we would expect to see continued growth through the year in that population.

And that, coupled with the age-ins, all the folks who are the baby boomers who are aging into Medicare through the year, we expect those to combine to provide a good growth opportunity for us.

We feel good about our benefit designs and the competitiveness there. One, the external validation that we have of our performance is, the receipt of these 16 senior gold choice awards, which is an independent third party that evaluates the economic value of our benefit package relative to those of our competitors.

And then, moving onto Medicare Part D and the drug benefits, as I said, we have approximately 900,000 members for January 1. This continues to be a good product for us. We think we are well-positioned. And while we are likely to see slight attrition in our membership through the year, given the outcome of the bidding for last year, this continues to be a strong, well performing product for us.

And it's really key to -- of our tripartite approach to serving the dual populations with Medicare Part C, Medicare Part D and Medicaid, in particular, for the markets where we are selling Medicare Advantage. An auto-assigned dual Part D member becomes a zero-cost lead that we can cross-sell into our Medicare product who is already carrying a WellCare card, and we already have both the opportunity and the obligation to develop a relationship with them.

And then having the scale and the data and the information that we get from a pharmacy benefit this size, of course, informs and helps us manage the pharmacy component of our HMO benefit packages. So it remains a very, very vital part of our strategy.

Speaking of growth related to health reform, two different dimensions to this. One is the Medicaid expansion, and this is one that we are looking forward to for 2014. What the chart illustrates here is in our existing Medicaid states, now including Kentucky, there are approximately 18.5 million Medicaid beneficiaries. And with the eligibility expansion that is expected through health reform that would be effective by 1/1 of 2014, estimates are that as many as 4.5 million additional individuals would come into the Medicaid programs in those states. So that would likely have a rising tide effect that we and many others would benefit from.

And then separately, the other dimension of the reform law that we think is going to be relevant to us, of course, is the exchange products. And while there's a lot of uncertainty about the ultimate design and administration of those products, we think that to the extent that, particularly for the lower-income strata of the people that are going to have an opportunity to become insured, to the extent that we are in the right neighborhoods and we already have health programs, we have the right networks, we have community partnerships that are attractive to our Medicare and Medicaid population, it's very likely that that would be attractive to these individuals. And frankly, many of them may already have carried a WellCare card or might a family member or friend or neighbor. And hopefully, if they have had a positive WellCare service experience and they like our network, they would choose us once they become insured.

I want to touch briefly on some highlights from our financial guidance. Our -- for full year 2011, we are expecting revenue in the $6 billion range. This should be approximately 11% increase over 2010.

In the aggregate our company-wide medical benefits ratio is going to come down. You see each of the components here. Again, we have made progress, approximately 60-basis-point reduction in our adjusted SG&A ratio for the year. And that does include the expenses that we incurred to

launch our Kentucky Medicaid program for the 11/1 effective date. And earnings per share on an adjusted net income basis of $5.55 to $5.65. Again, this is as of our last earnings call on November 2.

Before I wrap up I also want to highlight the financial strength of our balance sheet. This goes to support our investment in our priorities, again, of quality, cost and growth. And we have made good progress year over year on the balance sheet.

And then finally, looking forward, we are going to continue to focus, as I mentioned, on the three priorities of quality, cost and growth. We see continued improvement towards our long-term financial targets of an SG&A ratio in the low 10%, based on our product and geographic mix, and an adjusted operating margin in the 3% to 5%. We think we are well positioned for growth based on our experienced team, our history in terms of managing the dual populations and, frankly, our recent successful growth in our various products and the successful launch of our Medicaid program in Kentucky on a very, very aggressive timeline.

So with that, I want to thank you for your time this morning and your interest in WellCare. Thank you very much.

John Rex - *J.P. Morgan - Analyst*

We will be breaking out in the Sussex Room.

Alec Cunningham - *WellCare Health Plans, Inc. - CEO*

Okay; breaking out in the Sussex Room. Thank you.
