



Understanding Private-Sector Medicare

A primer for investors

November, 2018

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Overview

This presentation is intended for informational purposes only to give the reader a basic understanding of the Medicare program and the private sector options offered by Humana in conjunction with the program. The information presented is current as of the date on the cover page, and Humana has not undertaken to update this information.

Additional detailed information on the Medicare program is available on the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) websites at www.cms.gov and www.hhs.gov.

Users of this presentation are encouraged to also read Humana's disclosures in its Form 10-K (annual), Form 10-Q (quarterly), and Form 8-K (current report) filings with the SEC. Those documents are available via the Investor Relations page of the company's web site (www.humana.com).



The Medicare Program

The Medicare Program

Administered by the Centers for Medicare and Medicaid Services (CMS), which is part of the United States Department for Health and Human Services

Originally enacted by Social Security Amendments of 1965. Restructured significantly via:

- Balanced Budget Act (BBA) of 1997
- Medicare Modernization Act (MMA) of 2003
- Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act (ACA and HCERA) of 2010 (collectively referred to as Health Insurance Reform Legislation)

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 physician services, outpatient hospital services, certain home health services, medical equipment and supplies, drugs that must be administered in a clinical setting, and other health services and supplies
- **Part C** – Created by BBA of 1997. Offers Medicare beneficiaries an array of private health plan options (HMO, PPO, and PFFS plans) as an alternative to Original Medicare. Part C plans were originally known as Medicare+Choice, but later changed to Medicare Advantage
- **Part D** – Created by MMA of 2003. Began coverage in 2006 for prescription drugs offered through private health plans. Part D coverage may be offered as a stand-alone plan, or in conjunction with a Part C plan

ACA and HCERA of 2010 affected Medicare Advantage by changing the calculation of base premium, imposing minimum medical loss ratio requirement, and instituting Quality Bonus Payments based on star ratings.

Types of Private-Sector Medicare Coverage

Medicare Advantage

- Health Maintenance Organization (HMO)

- Preferred Provider Organization (PPO)

- Private Fee-for-Service (PFFS)

- All of the above plans may include Part D prescription drug coverage

Prescription Drug Plan (PDP)

Medicare Supplement (Medigap)

Overview of Medicare Advantage

Provides Medicare beneficiaries with private health plan options (HMOs, PPOs, and PFFS plans) as alternatives to Original Medicare

Participants generally receive better benefits than Original Medicare, which typically include supplemental benefits*, prescription drugs, reduced cost sharing, care coordination, disease management programs, tools to guide members in their health care decisions, and wellness and prevention programs.

Plans may include a Part D prescription drug benefit (MA-PD)

Operates with an Annual Enrollment Period (AEP) from October 15 through December 7 during which beneficiaries can select their plan choice for the following calendar year

Starting in 2019, there will be an Open Enrollment Period (OEP) from January 1 through March 31 during which Medicare Advantage members have a one-time opportunity to drop coverage, change to Original Medicare, or choose a different Medicare Advantage plan

*Supplemental benefits can be traditional such as dental, vision or hearing, or non-traditional benefits recommended by a licensed medical professional to address social determinants of health such as food insecurity or isolation

Humana Medicare Advantage Networks

HMO and PPO plans may eliminate or reduce coinsurance or deductibles on many other medical services while requiring care from participating providers.

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. Network PFFS plans have in and out of network benefits. Partial network PFFS plans have certain services with in and out of network benefits such as laboratory services and durable medical equipment. 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. Non-network PFFS plans may only be offered in geographies with less than two coordinated care plans (i.e. network plans such as HMO or PPO) available to beneficiaries.

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

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 a plan of their own selection (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

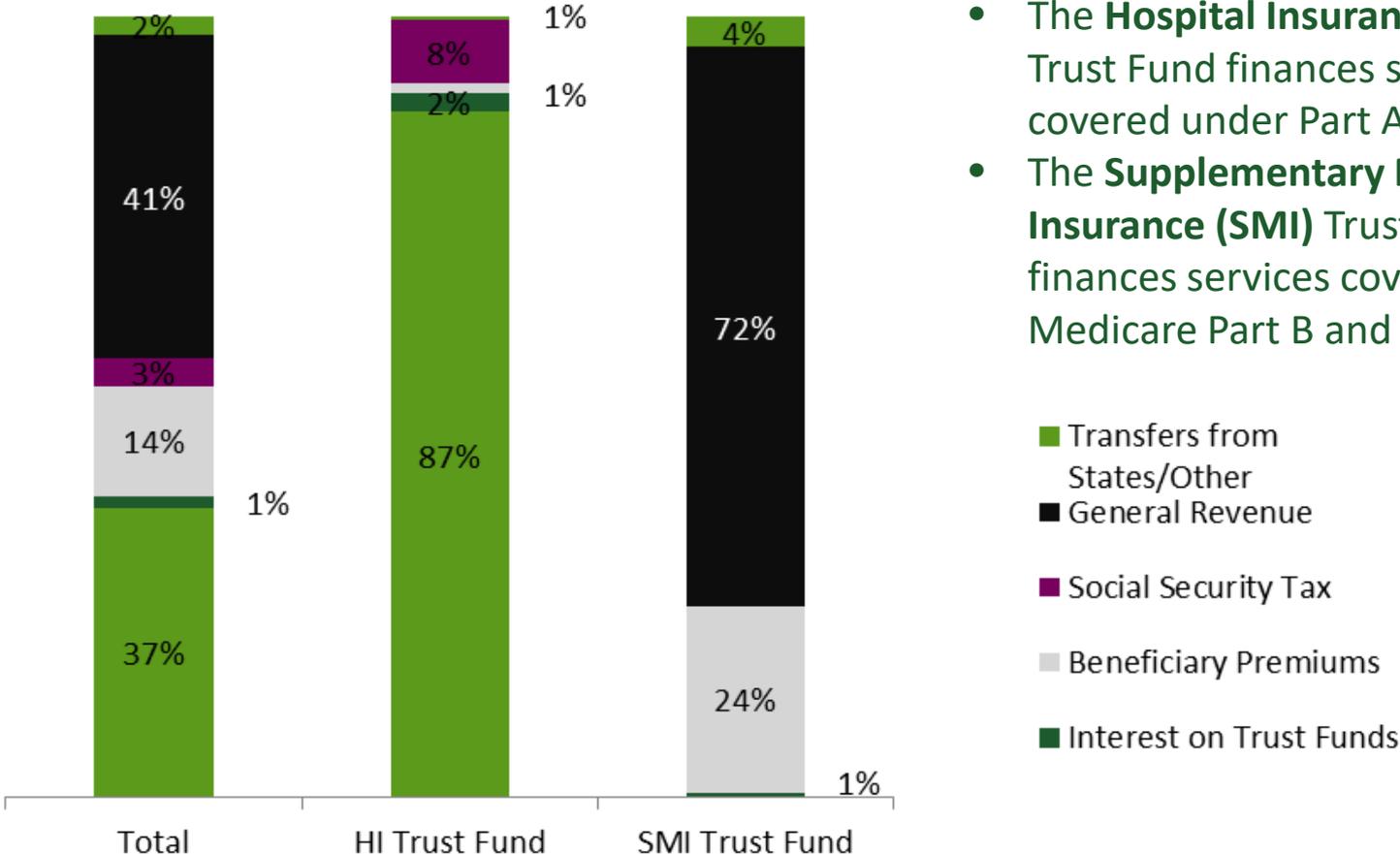
Defined Standard Benefit PDP

There are four phases of coverage in the Defined Standard Benefit:

1. **Deductible:** Member pays 100% of their initial annual drug spend up to a modest amount
2. **Initial Coverage Limit (ICL):** After the Deductible has been met, Member pays 25% of drug spend and Plan pays 75%, up to a pre-determined total.
3. **Coverage Gap (“Donut Hole”):** Originally, a Member paid 100% of the drug cost in this phase, up to a more substantial pre-determined Out-of-Pocket Threshold (OOP). Through the Affordable Care Act, the “donut hole” is now scheduled to be phased-out by 2020 for applicable beneficiaries with the following cost share percentages:
 - Generics – member cost share will be 25% and plan cost share will be 75% (2020)
 - Brand name – member cost share will be 25%, plan cost share will be 5% and drug company cost share will be 70% (2019)
4. **Catastrophic:** Once a member exceeds the OOP Threshold, “Catastrophic” coverage kicks-in. The Member pays a much smaller share of spend, approximately 5%, the Plan pays 15%, and CMS pays 80% of the cost.

Note: For individuals that meet various income and resource thresholds, full to partial subsidies for both premium and cost sharing are available.

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

Source: Calendar Year 2017 Data Reported in 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1



Payments to Health Plans

Sources of Medicare Advantage Premium

CMS Part C base premium per member is specific to the county in which the member resides. Contracts that earn a Quality Star Bonus rating of 4 or greater receive a higher base premium. This table of county premiums is known as the Medicare Advantage Ratebook.

- For Regional PPO plans, a portion of the base premium is determined by the average of bids from all companies' Regional PPOs in each plan's service area

CMS Part D base premium is a single amount that applies to all Part D coverages nationwide

Individual member risk adjustments may increase or decrease CMS premium

Member premium paid by the individual member to the health plan

- Members with low financial resources may qualify for CMS premium subsidies

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

The following slides provide more information on the above sources

Medicare Advantage Premiums – Quartiles

CMS Part C base premium per member is established by county

The Medicare Advantage base premium for each county is equal to the Original Medicare Fee-For-Service expenditure for that county (FFS Rate) multiplied by a percentage. The percentage is determined by each county's Payment Quartile as follows:

Payment Quartile	Base Premium
First 25% of counties with highest FFS Rates (e.g. Miami-Dade, Florida)	95% × FFS Rate
Second 25% of counties with next highest FFS Rates	100% × FFS Rate
Third 25% of counties with next highest FFS Rates	107.5% × FFS Rate
25% of counties with lowest FFS Rates	115% × FFS Rate

Per [March 2018 Report to the Congress: Medicare Payment Policy](#) published by MedPAC, 2018 Medicare Advantage plans are paid, on average, approximately 1% above FFS Rates.

Medicare Advantage Premiums – Quality Star Bonus Payments

CMS evaluates each Medicare Advantage contract's quality of care on a scale from 0 to 5 stars. Contracts that earn a star rating of 4 or greater have their base premium per member increased by $5\% \times \text{FFS Rate}$.

- A company may offer Medicare Advantage plans under multiple contracts, each with its own star rating.
- The company may offer multiple plans under each contract

A new contract does not receive its own star rating for the first three years, but instead receives the enrollment weighted average star rating of the company's other Medicare Advantage contracts.

If a company does not have any Medicare Advantage contracts with star ratings, or if, after three years, a contract has membership that is too low to calculate a star rating, the contract's base premium per member is increased by $3.5\% \times \text{FFS Rate}$.

Risk-Adjustments

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

Coding of individual claims affects the health 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 health risk scores 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 health risk scores using most recent encounter submissions and makes any necessary adjustments to plan-year premium

Sources of Payments to PDPs

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

PDP Member Premiums Computation

Basic Member Premium

Revenue for basic benefit adjusted to standard risk score of 1.0 ^(a)
less national bid average ^(b)
plus national base member premium ^(b)

Supplemental Member Premium

Projected revenue for supplemental benefits

a) Projected PDP revenue excluding reinsurance subsidy Divided by projected risk score used in projected PDP revenue (based on plan bids)

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

Minimum Medical Loss Ratio (MLR) Requirements

- In May 2013, CMS issued final rules related to the minimum MLR requirement mandated by the Affordable Care Act for Medicare Advantage and Medicare Part D plans.
- Beginning in 2014, Medicare Advantage and Part D prescription drug plans must spend at least 85% of premiums for medical benefits each contract year. The specific regulatory compliance calculation involves certain adjustments to both premiums and medical benefit expenses and, as a result, may differ from benefit ratios shown in published financial statements.
- If minimum MLR targets are not met, plans will be required to remit payments to CMS. These remittances are equal to the total revenue under the contract for the year multiplied by the difference between the 85% minimum and the contract's actual MLR.
- If a plan does not meet minimum MLR requirements for three consecutive years, no new enrollment will be allowed in the next contract year. Plans failing to meet the minimum MLR requirement for five consecutive years will be subject to contract termination.

Annual Bidding Process



Medicare Advantage Annual Bidding Process

Timeframe	Event
First Monday in April	CMS publishes Medicare Advantage Ratebook and bidding instructions for the following year.
April and May	Company evaluates data and benefit plan designs to determine bids.
First Monday in June	Companies submit Part C bids for each MA plan to be offered the following year. If the MA plan also includes prescription drug coverage, a separate Part D bid is also submitted for each such plan.
June and July	CMS reviews bids for adequacy and appropriateness of plan designs.
August	Final Regional PPO base premiums are published by CMS. Bids are finalized based on new base premiums and Part D benchmarks described in next slide
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 evaluates 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 (in each Part D region, the 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	<p>CMS publishes the average of Part D bids for the standard plan which determines CMS premium.</p> <p>Bids are adjusted to reflect actual CMS premium and the related effect on member premiums.</p>
September	<p>CMS signs final contracts for upcoming year.</p> <p>Automatic assignment of low income PDP beneficiaries to PDPs whose bids are less than the Part D regional benchmark (to be effective January 1).</p>



Part D Risk Share

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

Part D 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 Prescription Drug Plans

PFFS – Private Fee for Service

PMPM – Per Member Per Month

PPO – Preferred Provider Organization

PDP – Prescription Drug Plan

Medigap – Medicare Supplement plan

Whom to Contact with Follow-Up Questions

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