Investor Relations Glossary of Terms

15% Solution – HUM clinical strategy to hold member medical costs to at least 15% below the cost of traditional FFS Medicare.

Accountable Care Organization (ACO) – Groups of affiliated doctors, hospitals, and other health care professionals organized to equip providers with appropriate tools, payment mechanisms, and incentives to support high quality health care outcomes and improved efficiency.

Administrative Services Only (ASO) – An arrangement between an employer or benefit trust and an insurance company, or third party administrator (TPA) where the insurance company or TPA does not assume risk, but performs only specifically contracted services, (e.g., claims processing, and/or utilization management), generally for pre-set administrative fees.

Annual Election Period aka Open Enrollment (AEP) – The time when Medicare eligible beneficiaries can change Medicare Advantage plan and/or Part D coverage, and/or return to Original Medicare. The AEP runs from October 15 – December 7 with any plan changes effective January 1.

Basis Point (bp) – one basis point equals 1/100 of one percent (e.g. an increase of 85.6% to 85.8% = 20 bp increase).

Benefit Expense Trend – The change in per member benefit expenses for the current period compared to the same period in the prior year.

Benefit Ratio – Benefit expenses as a percent of premium revenues (also known as medical expense ratio – MER, medical loss ratio – MLR).

Bureau of Labor Statistics (BLS) - The principal fact-finding agency for the Federal Government in the broad field of labor and economics and statistics.

Capital Expenditure (Capex) – Amount used during a particular period to acquire or improve long-term assets such as property or equipment and other fixed assets.

Capitation – A method of paying medical providers involving a pre-established amount for each covered person. The payment covers all specified services received by the covered person, regardless of the volume of services received by covered persons or the costs incurred by a provider in furnishing those services. The pre-paid amount frequently is adjusted to reflect the demographic characteristics (age/sex) of the members served by the provider(s).

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. This agency administers the Medicare program and works in partnership with the states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), health insurance portability standards, and other programs.

Coinsurance – The amount, usually a percentage of the total cost, required to be paid by the patient for medical services after paying any deductibles.

Copayment – The amount, usually a set amount, required to be paid by the patient for medical services after paying any deductibles.

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Days in Claims Payable (DCP) – Benefits payable at the end of the period divided by average benefits expenses per day in the period. Similar to the standard financial Days Payable Outstanding metric.

Debt to Capital Ratio – A measurement of a company's financial leverage, calculated as the company's debt divided by its total capital. Debt includes all short-term and long-term debt. Total capital includes the company's debt and total shareholders' equity as reported on the company's balance sheet.

Deductible – The portion of the covered member's health care expenses that must be paid by the member before the member's plan begins to pay its share.

Department of Health and Human Services (HSS) – A department of the federal government whose mission is to enhance and protect the health and well-being of all Americans. The department fulfills that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services. HHS implements parts of the Affordable Care Act that deal with private and public insurance.

Department of Insurance (DOI) – State agencies that regulate insurers.

D-SNPs – Dual Eligible Special Needs Plans enroll beneficiaries who are entitled to both Medicare and Medicaid, and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Dual – See Dual Eligible.

Dual Eligible – An individual that qualifies for both Medicare (Part A and/or Part B) and Medicaid benefits. Sometimes referred to as a Dual or MME.

Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA) - A measurement of profitability in which interest, taxes, depreciation, and amortization are added back to net income, which eliminates the effects of financing and accounting decisions.

Earnings per Share (EPS) - The portion of a company's net income attributed to each outstanding share of common stock. Typically, computed as net income in a given period divided by weighted average shares outstanding for that period.

Employee Assistance Program (EAP) – Services to employers that assist employees in dealing with personal problems (e.g., alcoholism, marital difficulties, emotional problems, financial problems).

Enterprise Value (EV) - A measure of a company's total value, often used as a more comprehensive alternative to equity market capitalization. It is generally expressed as the sum of debt, common equity, and any preferred equity.

Explanation of Benefits (EOB) – A summary of the payments made by an insurer or health plan on behalf of an insured to a health care provider and any appeal rights the insured may have.

Federal Poverty Level (FPL) - A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain government programs and benefits.

Federally Facilitated Marketplace (FFM) - An organized marketplace that is operated by the federal government in states that have chosen not to build and operate their own marketplace. For further information, refer to Public Exchange.

Fee-for-Service (FFS) – Payment mechanism based on specific amounts for specific services rendered on a service unit basis.

Form 8-K – Securities and Exchange Commission "current report" used to report certain events or provide additional information that has previously not been reported by the company in a quarterly report (Form 10-Q) or annual report (Form 10-K). An example of these events or changes would be an acquisition or sale of significant assets not made in the ordinary course of the company's business.

Form 10-K – A report that a publicly-traded company must file with the Securities and Exchange Commission on an annual basis. It provides a comprehensive overview of the company's business and financial condition. Form 10-K must be filed with the Securities and Exchange Commission within 60 days after the end of the company's fiscal year.

Form 10-Q – A report that a publicly-traded company must file with the Securities and Exchange Commission on a quarterly basis. It includes unaudited financial statements and provides an updated view of the company's results and financial position since the filing of the last Form 10-K and/or most recent Form 10-Q. The report must be filed for each of the first three fiscal quarters of the company's fiscal year and is due within 40 days of the close of the quarter.

Generally Accepted Accounting Principles (GAAP) – The overall conventions, rules, and procedures that define accepted accounting practice at a particular time in the U.S. A combination of promulgations by accounting governance bodies, the Securities and Exchange Commission, and industry practice within a particular sector.

Global/Full Risk – A contractual arrangement in which a primary care provider is paid a fixed percent of premium (based on a MER target) for each assigned member and bears risk for all medical costs associated with those members.

Health Benefit Ratio (HBR) - Refer to Benefit Ratio.

Health Insurance Fee (HIF) - The enactment of health reform imposed an annual premium-based assessment on health insurance providers. The annual health insurance industry fee levied on the insurance industry was $8 billion in 2014 with increasing annual amounts thereafter, growing to $14 billion by 2017, and is not deductible for tax purposes.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law enacted in 1996 with many provisions that established national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. It also contains provisions designed to make it easier for individuals to avoid lapses in health coverage when transferring from one employer to another.

Health Maintenance Organizations (HMO) – A type of coordinated care plan involving a network of providers from whom members receive all health care (other than emergency care while traveling outside of the network area.) An HMO typically involves selection of a primary care physician who coordinates all care, including services of providers such as specialists and hospitals.

Health Risk Assessment (HRA) – An assessment of an individual's health used to identify potential healthcare needs. Also used to establish initial clinical care plans.
HumanaOne – Humana's health insurance product for the individual market.
Incurred But Not Reported (IBNR) – Claims that have been incurred by the member, but which have not yet been reported to the insurer.
Indemnity Insurance – A type of health plan product which reimburses for covered health care services received from any health care provider selected by the member. Coverage may be subject to deductibles and coinsurance, with member cost sharing generally limited by out-of-pocket maximums.
Integrated Care Delivery (ICD) Model – Humana's approach to primary care physician-directed care for the company's members that aims to provide quality care that is consistent, integrated, cost-effective and member-focused. Through aligned incentives and real-time actionable information, the model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering Humana members a simple, seamless health care experience.
Last Twelve Months (LTM) – A period of time commonly used to evaluate financial results such as a company's performance or investment returns.
Long-Term Services and Support (LTSS) – Services and supports used by individuals with functional limitations and chronic illnesses who need assistance to perform routine daily activities.
Management Services organization (MSO) – An entity that owns or operates clinics with employed primary care physicians or provides administrative services (e.g., contracting, billings/collections), assets (e.g., office space, medical equipment), risk management/population health (e.g., case management, disease management), and/or data reporting and analytics services to affiliated primary care physicians. At HUM, MSO typically refers to organizations operating clinics under global/full risk arrangements or providing services to affiliated physicians operating under global/full risk arrangements.
Market Capitalization – A company's market value calculated by multiplying the price of the company's stock by the number of shares outstanding.
Medical Benefit Ratio (MBR) - See Benefit Ratio.
Medical Care Ratio (MCR) – See Benefit Ratio.
Medical Cost Trend – See Benefit Expense Trend.
Medical Expense Ratio (MER) – See Benefit Ratio.
Medical Loss Ratio (MLR) – See Benefit Ratio.
Medicaid – A federal program administered and operated individually by participating state and territorial governments that provide medical benefits to eligible persons with low income and limited resources that need health care. The costs of the program are shared by the federal and state governments. Medicaid programs vary from state to state, but most health care costs are covered if an individual qualifies for both Medicare and Medicaid.

Medicare – A social insurance program enacted in 1965 that is financed by a combination of payroll taxes from workers and their employers, beneficiary premium payments, and general federal revenues. The program provides health coverage for people age 65 and over, those who have permanent kidney failure requiring dialysis or transplant, and certain individuals under 65 with disabilities.
Medicare Advantage – A Medicare program that gives beneficiaries the opportunity to select private health plans to provide their Medicare coverage. The private health plans often provide greater benefits than are available under traditional Medicare coverage, but may limit the members' choices among providers.
Medicare Modernization Act (MMA) – Enacted in 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made the most significant changes to the Medicare program since its passage in 1965. The law provides more choices in Medicare Advantage coverage and added prescription drug coverage to the program for the first time.
Medicare Risk Adjustment (MRA) – A multifactor score based on documented health conditions and demographics that is then applied as a multiplier against the benchmark premium from CMS.
Medicare Supplement – A policy guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and co-payments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, a Medicare Supplement policy pays for all or a portion of the cost of services not covered by Medicare.
Medicare and Medicaid Enrollee (MME) – See Dual Eligible.
Mergers and acquisitions (M&A) – A general term used to refer to the consolidation of companies. A merger is a combination of two companies to form a new company, while an acquisition is the purchase of one company by another in which no new company is formed.
Military Services – Encompasses both the TRICARE line of business and various contracts with the Department of Veteran Affairs.
Next Twelve Months (NTM) – Refers to any financial measure that is being forecasted for the immediate next twelve months from the current date.
Non-risk – A provider arrangement where HUM bears all risk for member medical costs and providers are paid on a fee-for-service basis.
Operating Costs – Expenses such as employees' salaries and related benefits, commissions, marketing and advertising, rent, insurance, and premium taxes.
Operating Cost Ratio – Operating costs as a percent of total revenues less investment income.
Over the Counter (OTC) Drugs – Drugs that can be purchased without a prescription.
Part D – See Prescription Drug Plan (PDP).
Patient Protection and Affordable Care Act (PPACA) – Enacted in 2010, PPACA reforms a multitude of aspects of the private health insurance industry and public health insurance programs, commonly called the Affordable Care Act (ACA).
Per Member Per Month (PMPM) – A measure of the average amount of revenue or expense incurred for each member in one month.

Pharmacy Benefits Manager (PBM) – An organization that may assist health plans in various administrative aspects of providing drug coverage, including generally claims payment.

Preferred Provider Organization (PPO) – Coordinated care arrangement involving a group of hospitals, physicians, and other providers who have contracts with an insurer, employer, third-party administrator, or other sponsoring group to provide health care services to covered persons. Under a PPO health plan, covered persons generally pay less when they use the providers in the PPO network than when using non-network providers.

Premium Yield – The change in per member premiums (after benefit buy-downs) for the current period compared to the same period in the prior year.

Prescription Drug Plan (PDP) – Prescription drug coverage, typically used to refer to Part D of the Medicare Modernization Act for Medicare eligibles.

Price Target (PT) – A projected price level as stated by an investment analyst that represents the analyst's assessment of expected price performance based on fundamental and market factors expected to drive valuation of an investment.

Prior Period Development (PPD) – The change in estimated claims expense based on more updated information as IBNR claims become reported claims.

Private Exchange – A tool designed for group customers that allows their employees to evaluate and select from multiple health insurance options. The exchange enables an employer defined contribution model, and can host multiple payor or single payor plan designs. In the case of a single payor private exchange, the tool can offer multiple plan designs and be used to cross-sell additional specialty products.

Producer Price Index (PPI) – The PPI measures the average change over time in the selling prices received by domestic producers for their output.

Public Exchange – Also known as health insurance exchanges, or simply exchanges. These are federal or state administered websites where individual consumers can compare plans and purchase health insurance.

Qualified Health Plan (QHP) – Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have certification by each Marketplace in which it is sold.

Risk Adjustment Data Validation Audit (RADV) – RADV is the process of verifying that diagnosis codes submitted for payment for an MA organization are supported by medical record documentation for an enrollee. CMS conducts MA risk adjustment validation procedures for the purpose of ensuring the accuracy and integrity of risk adjustment data and MA risk adjusted payments.

Regulation Fair Disclosure (Reg FD) – Securities and Exchange Commission regulation that aims to promote the full and fair disclosure of material information to investors. Reg FD provides that issuers are not to disclose material nonpublic information to certain individuals or entities – generally, securities market professionals, such as stock analysts, or holders of the issuer's securities – that is not publicly available. Should the issuer inadvertently do so, the issuer must make immediate public disclosure of such information.

Required Surplus – This is an amount governed by each state where a regulated insurance company is licensed. It equals the minimum level of capital and surplus (statutory equity) required to demonstrate sufficient financial solvency. Often the RBC calculation governs this requirement.

Return on Invested Capital (ROIC) – A calculation used to assess the company's efficiency at allocating the capital under its control to profitable investments. The return on invested capital measure gives a sense of how well the company is using its resources to generate returns. Calculated as net income as a percentage of total capital. Total capital includes the company's debt and total shareholders' equity as reported on the company's balance sheet.

Risk Based Capital (RBC) Calculation – An algorithm developed and maintained by the National Association of Insurance Commissioners to calculate the required level of minimum capital and surplus (statutory equity) required to demonstrate sufficient financial solvency. For a given entity, the RBC calculation quantifies the level of risk and the required level of statutory equity to cover the uncertainties of 1) credit risk, 2) asset risk, 3) underwriting risk, and 4) business risk.

Sarbanes-Oxley Act (SOX) – Legislation enacted July 2002 that redesigned federal regulation of financial reporting and governance of publicly-held companies. It significantly tightens accountability standards for CEOs, CFOs, boards of directors, auditors and others. There are two sections that appear to have been receiving the most attention from investors: (1) Section 302 requires CEOs and CFOs to sign statements under penalty of perjury, verifying the completeness and accuracy of company financial statements, and (2) Section 404 requires CEOs, CFOs and outside auditors to attest to the effectiveness of internal controls for financial reporting.

Securities and Exchange Commission (SEC) – A federal agency that regulates the U.S. securities markets. The SEC also oversees the securities industry and promotes disclosure of material information to the investing public.

Selling, General, & Administrative Expense (SG&A) – SG&A expense is reported on the income statement and is the sum of all direct and indirect selling expenses and all general and administrative expenses of a company.

STAR Ratings – Quality ratings of MA plans by CMS. Ratings are on a 1-5 scale, with 1 star representing poor performance, 3 stars representing average performance, and 5 stars representing excellent performance. Ratings are based on performance measures compiled through survey, clinical, and administrative data. Beginning in bonus year 2015, only 4 Star and above plans will receive bonus payments. 5-Star plans are permitted to enroll year-round.

Statutory Accounting – A separate basis of accounting required by the National Association of Insurance Commissioners (NAIC), which focuses on the solvency of state regulated insurance companies.

Stop-loss – A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. This may apply to an entire health plan or to any single component.

Subrogation – A health benefits company may reserve the "right of subrogation" in the event of a loss. This means that the company may recover the amount of benefits paid by the company for injuries to an insured individual in a case in which the insured individual is subsequently reimbursed for the injury by a third party whose conduct was alleged to have caused it.
Temporary Assistance for Needy Families (TANF) – TANF replaced several welfare programs under welfare reform legislation of 1996 including Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides States, territories and tribes federal funds each year. These funds cover benefits, administrative expenses, and services targeted to needy families.
TRICARE – Part of Humana's military services business. Medical coverage program sponsored by the Department of Defense (DoD). The DoD contracts with select health insurers to be the sole providers of health benefits coverage in defined regions of the country on an insured basis to the beneficiaries of the military and military retirees and on an ASO basis for active duty military personnel.
Year-Over-Year (YOY) – A method of evaluating two measured events by comparing the results as of one time period with those from the similar time period (or series of time periods) a year earlier.