Humana (HUM) Earnings Report: Q1 2015 Conference Call Transcript

The following Humana conference call took place on April 29, 2015, 09:00 AM ET. This is a transcript of that earnings call:

Company Participants
- Regina Nethery; Humana; IR
- Bruce Broussard; Humana; President, CEO
- Brian Kane; Humana; SVP, CFO
- Jim Murray; Humana; EVP, COO

Other Participants
- Joshua Raskin; Barclays Capital; Analyst
- David Windley; Jefferies; Analyst
- A.J. Rice; UBS; Analyst
- Andrew Schenker; Morgan Stanley; Analyst
- Matthew Borsch; Goldman Sachs; Analyst
- Peter Costa; Wells Fargo Securities; Analyst
- Kevin Fischbeck; Bank of America Merrill Lynch; Analyst
- Sarah James; Wedbush Securities; Analyst
- Scott Fidel; Deutsche Bank; Analyst
- Ralph Giacobbe; Credit Suisse; Analyst
- Ana Gupte; Leerink Partners; Analyst
- Christine Arnold; Cowen and Company; Analyst

MANAGEMENT DISCUSSION SECTION

Operator:

Good morning. My name is Melissa and I will be your conference operator today. At this time I would like to welcome everyone to the Humana first-quarter 2015 earnings call. (Operator Instructions)

Thank you. I will now turn the call over to Ms. Regina Nethery. You may begin your conference.

Regina Nethery (IR):

Thank you and good morning. In a moment Humana’s senior management team will discuss our first-quarter results and our updated earnings outlook for 2015. Participating in today's prepared remarks will be Bruce Broussard, Humana's President and Chief Executive Officer, and Brian Kane, Senior Vice President and Chief Financial Officer.

Following these prepared remarks, we will open up the lines for a question-and-answer session with industry analysts. Joining Bruce and Brian for the Q&A session will be Jim Murray, Executive Vice President and Chief Operating Officer, and Christopher Todoroff, Senior Vice President and General Counsel. We encourage the investing public and media to listen to both management's prepared remarks and the related Q&A with analysts.
This call is being recorded for replay purposes. That replay will be available on the investor relations page of Humana’s web site, Humana.com, later today. This call is also being simulcast via the Internet along with a virtual slide presentation. An Adobe version of today’s slide deck has been posted to the investor relations section of Humana’s web site.

Before we begin our discussion, I need to advise call participants of our cautionary statement. Certain of the matters discussed in this conference call are forward-looking and involve a number of risks and uncertainties. Actual results could differ materially.

Investors are advised to read the detailed risk factors discussed in this morning’s earnings press release, as well as in our filings with the Securities and Exchange Commission. Today’s press release, our historical financial news releases, and our filings with the SEC are all available on Humana’s investor relations web site.

Call participants should also note that today’s discussion and slide presentation include financial measures that are not in accordance with generally accepted accounting principles. Management's explanation for the use of these non-GAAP measures is included in today’s slide presentation, as well as a reconciliation of GAAP to non-GAAP financial measures. Finally, any references to earnings per share or EPS made during this morning’s call refer to diluted earnings per common share.

With that I will turn the call over to Bruce Broussard.

Bruce Broussard (President, CEO):

Good morning, everyone, and thank you for joining us. This morning Humana announced first-quarter 2015 adjusted earnings per share of $2.47, up 5% from the first quarter of last year. Our pretax earnings of $744 million were at a record high and we believe a clear demonstration of the progress we continue to make as a company. Further, we continue to have confidence in our full-year guidance for adjusted earnings of $8.50 to $9 per share.

Our more significant achievements during the quarter included substantial membership growth in our Medicare Advantage, stand-alone PDP, and Humana One products; the recent launch of our population health technology business, Transcend Insights; announcement of the pending sale of our Concentra business; and completion of our $500 million accelerated share repurchase program. I will begin with our Medicare Advantage growth.

As we shared with you last quarter, we experienced another successful Medicare enrollment season for 2015. Individual Medicare Advantage membership at March 31, 2015, was up 11% versus the end of the fourth quarter 2014, up 14% year-over-year. We continue to see the positive impact for our members of stability in our value proposition, as well as high star quality ratings.

A recent McKinsey study on the 2015 star ratings concludes that HMO plans performed best on an enrollment-weighted basis. Approximately 56% of our individual members are in HMO plans compared to 53% a year ago. Further, the McKinsey study indicates that plans built around integrated delivery networks achieve higher average star ratings.

CMS recently eliminated certain fixed thresholds for four-star ratings for 2017 bonus year. These changes may result in some pressure on our overall star ratings, but we believe we will sustain our solid competitive advantage. We expect we will maintain our high-quality ratings due to our successful integrated care delivery model. Our model includes use of data analytics to engage members in preventative measures and wellness programs that closed clinical gaps in care.

In sum, we believe the combination of a solid value proposition and high quality ratings are critical to
attracting new membership and retaining our existing membership base. Our projected 2015 net new membership gains of approximately 12%, including a voluntary retention rate of approximately 90%, are all helping to validate this belief.

CMS has also recently released its final Medicare rates for 2016. While we were encouraged by the average rate increase for the first time in seven years, this average still lags fee-for-service medical cost trends. Additionally, CMS’s transition to the new risk adjustment model will negatively impact certain of our markets that are leading the country in value-based reimbursement methods and holistically assisting members with multiple complex chronic conditions, both of which are key goals for CMS.

As we prepare our Medicare bids for 2016, we will seek to minimize any disruption that rate changes may cause to Medicare beneficiaries, while holding firm on our 4.5% to 5% pretax margin target. The continuing investment in our clinical model are expected to provide some offsets to rate pressures; that will vary, of course, from market to market. Those investments were highlighted this month by Humana at Home’s acquisition of Your Home Advantage, a leading provider of nurse practitioner in-home visits.

Additionally, we believe our focus on the consumer experience and our proprietary market point distribution channel will be important elements in solidifying our relationship with our members as we face these rate challenges at the market level.

Turning to our stand-alone PDP offerings, we also experienced significant growth for these products with membership up 10% since the end of 2014 and 14% to the first quarter of last year. Primarily in our low price point offerings.

I now will spend some time on our investments in healthcare exchanges and state-based contracts. We are pleased that Humana One membership has continued to grow nicely. While we will continue to project at least breakeven results for our Humana One business, our projected increase reliance on the 3Rs is driven primarily by the results for the state of Georgia and our out-of-network provider usage.

We believe both are isolated and addressable. Brian will discuss each of these factors in his remarks.

Entering a new customer segment is never an easy task; however, we believe that healthcare exchanges are a leading example of the ongoing movement to the retail model where we have been so effective in Medicare. We continue to be highly targeted in terms of where we will participate in healthcare exchanges, with a strong emphasis on current Medicare Advantage markets to enable customer migration as members’ life situations change.

Our expansions into healthcare exchanges and our state-based contracts are deepening our partnership with local market providers as we develop local market scale through multiple product offerings. State-based Medicaid membership, which now includes those members associated with dual demonstration programs, is up significantly, both on a sequential basis and year-over-year. We continue to monitor the RFP pipeline and plan to pursue other state-based opportunities later in 2015.

These opportunities would not be as viable if it weren’t for our integrated care delivery model. Importantly, we continue to show progress in key integrated care delivery model metrics. Some examples include the number of individual Medicare Advantage members covered by value-based arrangements is now more than 54%. This is particularly encouraging, given the substantial increase in membership this quarter.

Membership in our Humana chronic care program is up 10% since the end of the year and 56% versus the prior year. Adoption of mail-order pharmacy among our members continues to grow as we highlight this benefit more fully during the sales process and welcome calls. Individual Medicare Advantage mail-order penetration is now, on an average, approaching 35%.
We continue to focus on reaching out to members with gaps in care and have sent over 4 million proactive messages to 2.5 million members to prevent gaps in care. These actions have resulted in a gap closure rate of more than 30%. As a leader in both the development and execution of value-based payment models and technology-driven population health management analytics, we support trends that encourage care coordination across all payers.

In that context, this quarter we launched Transcend Insights, which leverages the population health capabilities we have developed in our Medicare Advantage business. Our goal is to provide payer-agnostic tools to our provider partners, allowing more of our members to be in value-based reimbursement models. As we have shared with you in the past, value-based arrangements have proven to lead to higher [HETA] scores, lower medical costs, and higher membership satisfaction.

Before closing I would like to spend a moment on our recently announced sale of Concentric. As we have said in previous calls, we review our various businesses on an ongoing basis to ensure each earns its cost of capital and is aligned with our integrated care delivery strategy. The Concentra acquisition was part of a multipronged approach to increase our capabilities of managing risk through primary care physicians. Our subsequent MSO acquisition and joint venture investments provided a more integrated primary care platform than Concentra.

Although it did not ultimately fit strategically, we were able to achieve an attractive price that will result in a gain versus our initial investment. Brian will speak more to the details of this transaction in his remarks.

We expect the transaction will close in the next few weeks. I want to thank all of our Concentra associates for their dedication to the consumer and to our company.

Several of you have asked for an update on our PBM evaluation. That work continues and we expect to provide a full debriefing on our analysis during the third-quarter earnings call in November.

In summary, we believe our robust organic membership and revenue growth, together with our proven superior clinical operating performance and disciplined capital allocation, all come together to provide our sustainable competitive advantage. Excluding the one-time gains that we expect from the Concentra sale, we continue to expect our full-year adjusted earnings per share to be in the range of $8.50 to $9 and look forward to providing you updates as the year progresses.

With that, I'll turn the call over to Brian for a more detailed discussion of our financials.

**Brian Kane (SVP, CFO):**

Thank you, Bruce, and good morning, everyone. As Bruce mentioned, the first quarter of 2015 produced strong results and continues to demonstrate the successful implementation of our integrated care delivery model. The attractiveness of our product offerings is resonating with our customers, as demonstrated by the continuing increases in our Medicare Advantage, stand-alone PDP, and exchange membership.

Consequently, we have raised full-year membership expectations for both stand-alone PDP and Humana One. Stand-alone PDP is being driven by higher retention that we are seeing post the open enrollment period, which is largely the results of fewer auto enrollees being reassigned. I will speak more to the Humana One business shortly.

With regard to our Medicare Advantage growth, early indications for our new members are positive as we evaluate individual market growth and performance. Additionally, the growth in our PBM and Humana at Home businesses remains unabated, with not only more volume driven by membership growth, but also
deeper penetration in terms of increased engagement as well as benefits from scale that are driving results.

First-quarter revenues for the healthcare services segment rose 26% versus the prior year and pretax earnings are up 24% year-over-year. The quarter had several developments that will be the focus of my remarks today. These include the following: the increase in our projected three receivables for the year, medical utilization and prior-period development, days and claims payable and cash flows from operations, the earnings implications of the Concentra transaction, and capital allocation.

Let's begin with our exchange business and the premium stabilization programs commonly called the 3Rs. Our conviction in our healthcare exchange strategy remains strong. We continue to focus on our key growth markets by offering high-value networks to drive affordability and access for our customers.

We believe that this strategy has been effective in successfully establishing a new growth business while providing a compelling product that our members value. Over time, we believe that Humana One will not only contribute meaningfully to our results, but it will also, as Bruce emphasized, advance our objectives of local market presence and scale with providers, while allowing us to offer a range of products that are relevant to our customers no matter their age or income circumstance.

As with any startup business, we have had our successes as well as our challenges. In terms of successes, our ACA compliant membership for Humana One is up 38% from the end of 2014, well ahead of our previous expectations. This was driven by better-than-forecast sales and lower-than-anticipated attrition. Consequently, we have adjusted our aggregate Humana One guidance to reflect higher projected membership in the ACA compliant business, which we also believe results in us approaching the scale we need for long-term success.

We continue to forecast that we will have at least breakeven results in 2015 and earn a reasonable return on capital in 2016, albeit that achievement of breakeven results this year now includes higher reliance on the 3Rs than previously anticipated coming into 2015. As you have seen from our release, we have increased our net 2015 3R guidance range to $450 million to $550 million with reinsurance accounting for approximately 75% and risk adjustment and risk corridors accounting for approximately 25% of the total.

As we have discussed in the past, there is an interplay between risk adjustment and risk corridors in that if we don't get the risk adjustment exactly right, a meaningful part of the balance, either positive or negative, is captured through the risk corridors.

As we evaluate our financial performance to date, including runoff claims from 2014, the drivers of the increase in full-year receivables related to the 3Rs are quantifiable and addressable. The first two Bruce mentioned in his remarks are higher-than-anticipated out-of-network utilization and poor results in our Georgia market. The last driver of the higher receivables is simply a function of having more members than we had previously expected.

I will start with out-of-network utilization. As the exchanges were rolling out across the nation, we believed there would be a time period during which our members would be getting accustomed to our efficient network products. Consequently, we permitted out-of-network utilization for the small proportion of our members who did not stay in-network to avoid disruption, notwithstanding the products design which underpinned the affordability that our members seek.

Our provider network team has thoroughly evaluated our networks in light of our membership levels by market and we are very satisfied in our level of network adequacy. As a consequence, we are in the process of implementing stricter enforcement of network utilization by working closely with non-network providers as well as educating our members on the product. Higher levels of in-network utilization are
anticipated to ensure the continued affordability of our healthcare exchange offerings, as well as align with our pricing assumptions for the remainder of the year and for 2016.

After adjusting for the out-of-network usage, our markets across the country, including our largest Humana One market in Florida, are performing within expectations with the notable exception of Georgia. One of the challenges we faced in both 2013 and 2014 was the immaturity of the claims data we had available at the time we set our healthcare exchange pricing for the following year versus what we would've preferred. Specifically, more detail regarding statewide market conditions and health status based on significant exchange claims data.

To help address this, we juxtaposed the limited Georgia claims data we had against claims data nationally for states that we believe had similar utilization patterns and mix of likely enrollees to derive assumptions from the population health of each state and, in turn, set our pricing. Recent actuarial claims data for the state of Georgia now indicate that enrollees in the state as a whole are skewing more towards being a less healthy state population than we had believed and had priced for. Consequently, we are accruing both a risk adjustment and risk corridor receivable.

It is important to recall that this was the original intent behind the premium stabilization programs, namely early year protection in this circumstance. We are, of course, incorporating our emerging experience into our actuarial assumptions and are taking the appropriate targeted actions through pricing and product design when we file our 2016 rates in the next few weeks to ensure that George’s results will be back on track for 2016 without reliance on the risk corridors.

As I mentioned, the remaining driver of the higher 3R balance relates to higher-than-projected growth of our ACA compliant business. This will result in higher 2015 receivables than we had expected, primarily associated with reinsurance.

Finally, a quick word on our 2014 3R accruals. As you will see, we have decreased reinsurance by approximately $50 million and have increased our risk corridors by around $40 million as an offset. As we have evaluated the runout of our 2014 claims, fewer of our members than anticipated will hit the reinsurance attachment point, which is the reason we have made this change.

Turning to medical utilization, we are watching very closely the hospital inpatient admissions per thousand data for our Medicare Advantage business. We have seen some of the hospital-published data which suggests higher Medicare usage of inpatient services and have also witnessed in the last number of weeks an uptick in inpatient authorizations.

For Medicare Advantage, we have projected a decline year-over-year in hospital admissions and for the first quarter we have seen that decline bear out. In other words, our trend vendors continue to result in lower admissions. However, during the last weeks of the quarter and into April, we are seeing an elevated level of authorizations for hospital admissions, which, although still declining, are slightly higher than we had anticipated.

Importantly, we have also seen data throughout the quarter that would suggest our cost per admit is lower than forecast, implying lower severity conditions are driving the admissions.

While it is too early to draw any conclusions from what I just described, especially as admissions tend to fluctuate, it is something that bears close watching as the actual claims experience develops over the coming months.

As was highlighted in this morning’s press release, we did see a lower level of favorable prior-period development than in last year’s first quarter. A meaningful portion of the lower prior-period development was anticipated due to the PPD for the first quarter of 2014 having been unusually high and as a result of
claims processing changes involving the implementation in early 2014 of a front-end review for Medicare claims. Front-end review enables us to improve the initial accuracy of claim payments, reducing the amount of overpayments recaptured later as part of prior-period development.

PPD was also adversely impacted by fourth-quarter flu claims that came through in the first quarter of 2015 across our lines of business. I will now turn to the balance sheet and operating cash flow. I will start with days and claims payable, or DCP.

You will note that we have revised the DCP table to exclude reinsurance associated with the 3Rs. Given that reinsurance reduces benefits expense, but does not impact the related benefits payable, it skews DCP trends over the three-year period of the program.

Days and claims payable during first quarter of 2015 declined by less than a day, driven primarily by the typical first-quarter increase in Part D claims associated with our Medicare Advantage business. That impact is included in the all other category of the DCP roll-forward table in our press release. Recall that our stand-alone PDP business is excluded from our days and claims payable calculation.

Much like our stand-alone PDP offerings, our Medicare Advantage Part D benefit designs generally have the plan, picking up substantially all the initial pharmacy claims, but covering less of the benefit as the year progresses. While the pharmacy expense associated with these members is in our DCP calculation, their related payable is relatively small due to the speed of processing pharmacy claims. Higher capitation and provider settlements also resulted in a slight decrease to DCP during the quarter, but importantly, this was more than offset by an increase in unprocessed and processed claims inventories.

Cash flow from operations is down versus the first quarter of 2014 as higher net income was more than offset by working capital items. Specifically, the increase in benefits payable which accompanies growing membership was smaller year-over-year due to the lower level of overall growth in average membership given the outsized growth we experienced in 2014. This pressured the cash flow from operations on a comparative basis by approximately $250 million in the quarter.

Working capital needs for our growing pharmacy business primarily accounted for the remainder of the Delta in the first-quarter cash flows. For the year, our operating cash flow guidance is largely unchanged other than reducing operating cash flow by guidance -- cash flow guidance by approximately $200 million at the midpoint, primarily reflecting the increase in the 3R receivable that I just discussed previously as well as the pending sale of Concentra.

Before closing, I will spend just a few minutes on capital allocation and earnings guidance. As Bruce said in his remarks, we announced this quarter the sale of our Concentra business. The timing of the signing of the definitive agreement triggered the need to recognize the gain on the establishment of a deferred tax asset and, thus, the $0.35 per share gain was included in our first-quarter GAAP results.

We expect this transaction to close in the next few weeks, so we have included the full impact of the transaction in our earnings guidance, both from a GAAP and an adjusted perspective. For GAAP, we are including a total projected gain from the sale in the range of $1.35 to $1.45 per share including the $0.35 tax gain. On an adjusted basis, excluding this one-time gain, we continue to forecast earnings per share in the range of $8.50 to $9 per share.

The sale of Concentra is expected to generate, net of taxes and deal expenses, approximately $1 billion in net proceeds. Before any anticipated use of these proceeds, the sale will result in $0.11 of 2015 EPS dilution. We continue to look for value-enhancing acquisitions, such as the Your Home Advantage deal we recently announced, that will advance our in-home capabilities as well as pursue additional share repurchase opportunistically. However, given where we are in the year, it is likely that a good portion of this dilution will persist.
With respect to share repurchase, this quarter we completed our $500 million accelerated share repurchase program. Additionally, holding true on our commitment to buy back $1 billion of stock by June of this year, we have entered into a 10b5-1 plan that we expect will complete that goal. You will note, however, that we have raised our guidance slightly for the average fully diluted share count, due largely to the higher-than-anticipated buyback price, which will have a several cent negative EPS impact.

Finally, our work around optimizing our portfolio continues to ensure that each of our businesses fits strategically and earns its cost of capital. More generally, we are encouraged by our progress and our prospects, all driven by execution around our integrated care delivery strategy.

With that, we will open the lines up for your questions. In fairness to those waiting in the queue, we ask that you limit yourself to one question. Operator, please introduce the first caller.

QUESTIONS & ANSWERS

Operator:

Joshua Raskin, Barclays.

Joshua Raskin (Analyst - Barclays Capital):

Thanks, good morning. Want to talk a little bit about the utilization trends that you guys are monitoring and just better understand what exactly is driving that. I think you mentioned publicly and from some of the hospitals, but I have to assume you are going off of more internal data.

So is there any specific lines of service, are there a specific type of lives, any geographies? Are these new members? Just any color on where this utilization is coming from.

Brian Kane (SVP, CFO):

Good morning, Josh. It's certainly from our own data that we are seeing a slight uptick in admissions over the last few weeks and into April. There's no specific geography that we would point to. It's something that we continue to evaluate.

I would note that, interestingly, not only are the unit costs of these admits lower, which as I said in my remarks suggests a lower severity of claims, but also our outpatient utilization seems to be down and our pharmacy utilization is in line. And so it's very early really to ascertain exactly what this is telling us. It's just something that we thought it would be very important to communicate because it's something that we are watching very closely and it's something that we always watch very closely.

Bruce Broussard (President, CEO):

Josh, just to build on what Brian talked about and the reason that he specifically addressed it in his opening remarks, is as we saw this we began to dive into a lot of the information relative to new members and what we call concurrent members. And actually the new members that just joined the plans, which were fairly significant, were seeing actually better utilization than the concurrent members. So that gives us comfort that there wasn't an issue with any of the markets that we grew in.

A lot of the deep dives that we are doing -- and there's a lot of work that we are trying to pull together -- would suggest that there's some respiratory issues that we are facing. So that leads us somewhat to a conclusion that it's maybe a longer extension of the flu. A lot of work needs to be done to get our arms around it, but we feel very confident about how it's progressing and we feel good about a lot of the things that we do from a process perspective. This looks like an isolated incident.

Joshua Raskin (Analyst - Barclays Capital):
Okay, that's helpful, Jim. And I guess just maybe help us understand the magnitude here. If you take holistically this uptick in inpatient utilization but then lower outpatient and RX in line -- and maybe it's just flu. If this were to persist through April, May, June, is this enough to change guidance or is this just something that is a pressure point and the reason we're still comfortable in a relatively wide range of EPS?

Brian Kane (SVP, CFO):

Josh, I would say if this persists as we see it, it's not something that would impact guidance, but it's something that we watch very closely. Obviously, to the extent there was a continued uptick and a greater uptick, that's something that would have that impact. But we're not seeing that right now.

Joshua Raskin (Analyst - Barclays Capital):

Okay, thanks.

Operator:

David Windley, Jefferies.

David Windley ( Analyst - Jefferies):

I'm going to shift over to Humana One. I wanted to understand if your change in or lack of change in age distribution in that book of business in the slide that you presented to us last quarter, yet fairly significant change in metal tier distribution, if essentially that adverse selection had anything to do with your additional reliance on 3Rs.

Brian Kane (SVP, CFO):

It's something we continue to evaluate. We certainly evaluate all of our metal tiers and try to understand where utilization is coming from, particularly in Georgia where we've seen that. I think it's fair to say that we're going to continue to evaluate as we go into 2016 our participation in the various metal tiers, and certainly our pricing will reflect the increased morbidity that we are seeing in that block.

I would also say that the out-of-network utilization is something that we think we can address in short order and so that will not be a recurring issue going forward.

David Windley (Analyst - Jefferies):

On the out-of-network, just to follow-up on that, is that something where you were essentially only lightly enforcing the existing policy or rule and now you are going to more stringently enforce? Or do you actually have to change the policy and is that possible intra-year?

Brian Kane (SVP, CFO):

I would say the former. It's something that we lightly enforce. As we were coming into this program with a new product with new customers, it was something that they were going to get accustomed to, the product design. Over the next few months, it's something that we will enforce the policy that exists. And that really, as I said in my remarks, goes both to working with providers or I should say the out-of-network providers and some of the reimbursement levels that we pay them, as well as educating our customers as to the product that they bought.

We believe strongly that the strategy that we have pursued is one that allows our customers to have a very affordable and compelling product and as we educate them, we think we will be able to get that out-of-network utilization under control.
David Windley (Analyst - Jefferies):

Great, thanks for taking the questions.

Operator:

A.J. Rice, UBS.

A.J. Rice (Analyst - UBS):

I'm going to go back to the comments that Bruce had made about there being some pressure from threshold eliminations on the stars program. Can you give us a little more color on how significant that would be? Are we talking about something that would impact you potentially in 2017? Is that the right way to think about it or is there some reason it would impact earlier?

Jim Murray (EVP, COO):

This is Jim Murray. It would be 2017. And as many of you know, we are in the process today and for the next several weeks of finalizing a lot of the work related to the benefit year 2017. The threshold elimination puts a little bit of pressure and what that would translate into is the number of members that are in four-star or greater plans.

A lot of the feedback that we are getting -- we have a team of people that comes before us every Friday to talk about the progress that we are making around a lot of the tactical steps that are a part of this whole process that goes over this two-month period. And we feel very good about where we are positioned. Some pressure related to the elimination by CMS of the threshold, but, frankly, feel pretty good about how things are playing out this year. And we should be favorably positioned relative to the competition like a lot of the good work that we do around the stars program.

Bruce Broussard (President, CEO):

A.J., I think it's just important to keep in mind that it is a relative measurement and so our performance is highly predicated on everyone else's performance. And I think, as investors have seen over the past few years, our clinical capabilities has really outperformed the industry as a whole. And we continue to be confident that we will be able to continue to outperform, even as these changes persist.

A.J. Rice (Analyst - UBS):

Okay. All right, thanks a lot.

Operator:

Andrew Schenker, Morgan Stanley.

Andrew Schenker (Analyst - Morgan Stanley):

Thanks, good morning. I was just hoping to follow-up on your comments around maybe some of the moving parts in guidance since we all last spoke. It sounds like the Concentra deal, as you pointed out in the press release, was originally going to be about $0.11 headwind to earnings this year. You also called out, Brian, the pressure on the impact from share repurchase related to stock appreciation here.

Now looking at guidance it seems like tax rate may have come down a little bit. Just curious what some of the other moving parts were that led you feel confident to maintain your guidance range maybe versus where it was last quarter. Thanks.

Brian Kane (SVP, CFO):
I think you outline some of the major issues that we are focused on. Concentra will pressure earnings by $0.11. The share repurchase and tax rates and the like is probably about $0.04, so it's sort of a $0.15 headwind coming into this quarterly call.

Again, we feel comfortable about reiterating our guidance of $8.50 to $9. And really what is going to drive that performance, as we said to the first question, is where does utilization ultimately end up? Right now we feel good about where we are, but that is something where we are very focused on that will ultimately drive the year's numbers.

**Bruce Broussard** (President, CEO):

I think the important point on the Concentra sale is it is a timing issue for us versus a long-term business problem. And as we think about the sale, we think about it that we are really allowing the Company to redeploy assets that will advance us strategically at a price that we feel was a very good value for we are doing. And now what we can do is take that and redeploy it, whether it's in capital structure alterations such as stock buybacks or acquisitions that will be more accretive long-term and strategically much, much stronger.

**Andrew Schenker** (Analyst - Morgan Stanley):

Thanks. Maybe if I could just squeeze one more in real quick. The healthcare services segment specifically here; a lot of moving parts related to Concentra as well as your home health acquisition. If you could just maybe talk about how those kind of offset each other, as well as maybe membership growth that allowed you to maintain revenue guidance. It seems like the only impact pretax results was related to the pretax gains, so just making sure I understand the moving parts there as well. Thank you.

**Brian Kane** (SVP, CFO):

Sure. As you'll see in the healthcare services segment guidance, we did adjust the revenue numbers and the like to comport with the divestiture of Concentra. I would say, more broadly, that as I said in my remarks, that business is performing extremely well.

Membership is growing pretty dramatically based on largely our Medicare Advantage and PDP growth. But we are also seeing better engagement with our members, both from a mail-order perspective on the pharmacy, which is very important, but also with Humana at Home as our analytical capabilities continue to identify people who would benefit from our Humana at Home capabilities.

And so the combination of those is really driving that performance. We feel very good about the range we have out there for Healthcare Services pretax.

**Andrew Schenker** (Analyst - Morgan Stanley):

Thank you.

**Operator:**

Matthew Borsch, Goldman Sachs.

**Matthew Borsch** (Analyst - Goldman Sachs):

If I could ask a question about the individual market, just with two parts. Number one, the extent to which you are seeing inflow of new members coming into the exchanges generally for this year. A peer company of yours earlier today talked about seeing less inflow than they had expected.
Secondly, just on Georgia; how you reprice in that market and avoid getting stuck in sort of an adverse selection spiral.

**Brian Kane** (SVP, CFO):

I think as far as new members I think really it's consistent with what we expected in terms of coming into the market. And actually feel reasonably good about the overall pool of what we received.

With Georgia there's no doubt, Matt, that that is something that we are very focused on. As you put in higher price increases are you going to attract the wrong members? Part of that is going to go to product design in the metal tiers that we participate in. So we're very cognizant of that risk and we are going to price appropriate.

**Matthew Borsch** (Analyst - Goldman Sachs):

Okay, thank you.

**Operator:**

Peter Costa, Wells Fargo Securities.

**Peter Costa** (Analyst - Wells Fargo Securities):

Getting back to the individual business again, why do you think you had the problem in Georgia? One of your competitors reported earnings earlier that has a number of low-priced silver plans in Georgia. Didn't seem to show the problem that you guys are having there.

Do you think it's local market related to you? Is it some cost disadvantage that you have in Georgia? And how do we avoid this from happening in another state down the road when the risk corridors and risk reinsurance goes away?

**Jim Murray** (EVP, COO):

Peter, this is Jim. I will take your question and we wondered how long before you would dial-in.

With respect to Georgia, as Brian said earlier, one of the things that we did at the very beginning was to take our individual legacy business into relativities to our small group block of business because that was a guarantee issue, population. We thought that was fairly close to what might ultimately happen on the exchanges.

And after that -- and that was done local market by local market -- we evaluated morbidities across a national basis with the help of an outside consulting actuarial firm. And as a result of that overall evaluation from a national perspective, we lowered some of our markets in expected morbidities.

With respect to Georgia, while other markets turned out just fine relative to that pricing philosophy, Georgia didn't. Another part of the Georgia issue has to do with the platinum plans, which you've asked about in the past.

One of the things that we are seeing with the platinum plans is that the philosophy or the strategy that we have enumerated in the past with you and others is that you need to have documentable risk conditions for the members that are heavier utilizers. And as we study the Georgia population as we are doing some of our risk adjustment work, we are seeing that the Georgia population, although heavier utilizers, don't have documentable risk conditions, which doesn't allow us then to get risk adjustment for them.
As a result of that, as Brian said, not only in Georgia but also in other states, we are evaluating that requirement as it respects our platinum plan strategies going forward. And you will see us take some actions relative to that.

**Peter Costa** (Analyst - Wells Fargo Securities):

That's helpful. And what is your strategy for avoiding this going forward in other states?

**Jim Murray** (EVP, COO):

Now we have a lot more actual claims information on which to set pricing and so, as we have done with all of our other products over the years, we're using actual claims to set our pricing. And so our pricing will be consistent with our desire that this block of business will produce a satisfactory return. A lot of what we have done up to this point has been models and estimates based upon other lines of business.

Now that we have gotten some real claims information relative to not only 2014, but 2015, that is how we will set our pricing going forward. And we feel very confident in our ability to properly set the right rates.

**Peter Costa** (Analyst - Wells Fargo Securities):

Will you offer platinum plans next year?

**Jim Murray** (EVP, COO):

We're going to evaluate that market by market and to the extent that it doesn't make sense because of what I talked about relative to documentable risk conditions, we will evaluate that and we will act accordingly.

**Operator:**

Kevin Fischbeck, Bank of America.

**Kevin Fischbeck** (Analyst - Bank of America Merrill Lynch):

Great, thanks. Just wanted to ask a little bit about the commentary on the Medicaid side of the business. The Company seems to be more aggressively pursuing RFPs than you have in the past. Can you talk a little bit about your view; what's changed in the last couple of years?

And you have pursued RFPs in a couple of different ways, outright or through joint ventures and things like that. How do you think about the form that these types of participation might take?

**Bruce Broussard** (President, CEO):

I don't think our posture has changed relative to what we look at going forward. I think we continue to believe a partnership model in Medicaid makes sense in most states, if not all states, and we will continue to do that.

We do look at states where we have existing membership, and as their RFPs come out we want to participate in those RFPs. That really has been a standard direction and strategy for us. Our existing Medicaid results continue to meet expectations and continues to grow quite nicely. And so as we look at them going forward we continue to believe that the Medicaid platform is a platform that has a partnership model in states that we are operating within today.

**Kevin Fischbeck** (Analyst - Bank of America Merrill Lynch):

Okay, great. Thanks.
Sarah James, Wedbush.

**Sarah James** (Analyst - Wedbush Securities):

Thank you. I would like to go back to the out-of-network utilization portion of the 3Rs, Bruce. It sounded like this was mainly something that pertained to new members transitioning on to an exchange product and there has been some stricter network enforcement going on lately and I guess going forward.

Should I think about this as really dipping into the 3Rs for just the first quarter and it’s adjusted going forward, or is this something that is going to continue on through the year? How can you modify your benefit designs in 2016 in a way that would improve this scenario?

**Brian Kane** (SVP, CFO):

I would say it’s going to impact the 3Rs for this year, just given where we are with our performance and the like. When people go out of network those are higher costs than we had anticipated and that drives the receivables.

As I mentioned in my remarks, we are working with these out-of-network providers, both in terms of the reimbursable fees that we pay them and the fee schedules; contracting with them and the like. And it’s also a matter of educating our members as to their product -- the product that they have. I would say we believe very deeply in the strategy of having these high-value networks that allows us to drive very affordable and attractive pricing to our members.

And so those are really the puts and takes. It’s a combination of provider and member education.

**Sarah James** (Analyst - Wedbush Securities):

So it’s more education and less of financial incentives?

**Brian Kane** (SVP, CFO):

I would say with the providers there would be financial impacts and financial incentives to ensure that we pay the appropriate levels of reimbursement for what we call our nonpar or our nonparticipating providers.

I should note it is a small -- it is a small number of members that are utilizing the benefit out of network, and to some extent there might be some product design in terms of higher out-of-pocket costs for members who tent to go out-of-network. And that’s something that we would be evaluating for next year.

But I think the combination of provider education, provider contracting, as well as member education and some tweaks in the product design, it is a problem that we think we can get our head around and solve for next year. And, frankly, the back half of this year as well.

Operator:

Scott Fidel, Deutsche Bank.

**Scott Fidel** (Analyst - Deutsche Bank):

Thanks. Just wanted to stick on the individual business and know you were talking about Georgia specifically. Just interested in how much you think you’re going to need to be raising premiums on the exchange business more broadly.
If we look at your 3Rs accruals now for this year, they are right around $0.5 billion for 2015 and I would calculate that on your sort of ACA compliant individual business that equates to around 13% of revenue. So given that both reinsurance and risk corridors really sort of scale away over the next year or two, just help us think about how much excess premium increases you're going to need to be implementing in order to reflect the expiration of those 2Rs or the 3Rs.

**Brian Kane (SVP, CFO):**

That's not a specific number, for obviously competitive reasons; we wouldn't want to comment on right now. I would say that certainly we have the 3Rs squarely in mind as we price for next year. We recognize there is one more year to go here with two of the three Rs and so we are going to price such that, as I said in my remarks, we can earn an attractive return on capital in 2016 and beyond.

And so we understand the dynamics of the market and the 3Rs and the pricing required to do that, and we will take the necessary steps to make sure we get the right financial return.

**Jim Murray (EVP, COO):**

To Brian's earlier point, many of the markets are performing well and we've got some problems in the state of Georgia that we plan to address with our pricing and product design.

**Scott Fidel (Analyst - Deutsche Bank):**

Okay. Then just quickly just on the Medicare hospital admission. How geographically broad based are you seeing that? I'm just trying to tie that into the comments for CMS on their final 2016 rates call where they said that their actuaries have also seen some flattening out of the admissions trends. I would assume if CMS was highlighting that that would probably be more of a broader base. Just interested geographically on how much you are seeing that.

**Brian Kane (SVP, CFO):**

I think, as Jim said earlier, we wouldn't call any specific geographies. Where we were very focused was to see where we grew in particular markets and whether that more outsized growth was the cause of this, the slightly higher admits. And when we haven't seen that they are actually running pretty favorably. So I would suggest it's a broad-based phenomenon that we are watching very closely.

**Scott Fidel (Analyst - Deutsche Bank):**

Okay, thank you.

**Operator:**

Ralph Giacobbe, Credit Suisse.

**Ralph Giacobbe (Analyst - Credit Suisse):**

Thanks, good morning. Switching a little bit, you guys have reclassified segments and I guess within the group book you have seen enrollment declines. I guess the question is how committed are you to this business? Going forward is there any strategic review being contemplated for this segment?

Then I guess separately just on the PBM, just want to clarify; you talked about a full debrief on the 3Q call in November. Just hoping to get a little more clarity on that. Is that just a final decision you expect at that point on whether you kind of keep it or come up with some sort of outsourcing arrangement or the like? Thanks.
Jim Murray (EVP, COO):

Your question on enrollment declines, we made the strategic decision a year or so ago, and I think we talked about that, that with the large group business we were going to wind that down over the next several years because we are not a national player and we can't compete in that space. But we are focused on what we call our sweet spot of smaller case sizes.

Over the last six months we performed reasonably well with our sweet spot focus. You may recall that in the fourth quarter we grew very nicely with our smaller focused business.

This past quarter we have seen some shrinkage in our fully-insured smaller case size membership as a lot of our competitors are implementing their new rates relative to community rating. And we are seeing a little bit of an aggressive posture in some of the states that we do business that will ultimately change over time and we think that that will work itself out. We feel very confident with our focus on the smaller case.

Over the next several years we are going to be evaluating our group business and, again, feel very good about its prospects for continued profitability. It serves very nicely as a complement to our focus on local market scale. We talk a lot about that with our Medicare business, our individual business, our Medicaid business, and our group business in certain of our, what we refer to as, bold move markets.

So, again, we feel very confident in our ability to compete and win in the smaller case size, and hopefully you will see that play out over the next several quarters.

Bruce Broussard (President, CEO):

Even as the results show this quarter, we really have a three-pronged approach within group. One is around continuing to increase our efficiency within the group sector and you can see that as you see our cost ratios coming down. The second is to focus on where we probably have better value proposition and that's in the small group business, as what Jim just talked about, our sweet spot, and begin to start exiting relationships that are not profitable for us. And that traditionally is the larger ASO model.

And then the third is to continue to migrate customers to more of a consumer choice model within the markets that we are at, and that would be both the private exchange and public exchanges as we see that being both a long-term trend; and frankly, I think where we can even add more value with our retail capabilities that we have had in the past.

Ralph Giacobbe (Analyst - Credit Suisse):

That's helpful. And just on the PBM?

Bruce Broussard (President, CEO):

As we said, the PBM we're going to evaluate and it's under continued evaluation. We've provided some updates in the past, but the full update will be in the third quarter of this year.

Ralph Giacobbe (Analyst - Credit Suisse):

Thank you.

Operator:

Ana Gupte, Leerink Partners.

Ana Gupte (Analyst - Leerink Partners):
Thanks, good morning. So I just want to make sure I understand this. I'm a little confused with everything. I'm getting a lot of questions from investors who are pretty confused as well.

On retail MLR, what exactly -- is the underlying Medicare MLR okay, ex PYD, and this sort of late quarter potential uptick you are seeing? And the deterioration, which was not great, but it is deteriorating because your Humana One individual public exchange product is now going to be much more reliant on reinsurance and you are having all these issues?

**Brian Kane (SVP, CFO):**

Again, if you look at our retail MERs for the quarter and you adjust them for prior period, they are actually down. So I think that is important to note.

As we said, prior period did have a pretty material impact on our numbers. A lot of it was expected; some of it wasn't related to the flu and the like. But when you look at the MERs we feel pretty good about where we are on incurred basis from an MER perspective. And as I said, they are actually down so I hope that answers your question.

**Ana Gupte (Analyst - Leerink Partners):**

Okay. So MA is in a good place. On individual, did you see any improvement in your off-exchange ACA compliant type MLR at all? Your competitors seem to be seeing what they said they would see. And so net-net, on individual you said you would see margin expansion, ex-exchange, public exchanges. What's going on in the rest of the book?

**Brian Kane (SVP, CFO):**

We don't break out our ACA compliant off-exchange and on-exchange. I think when you adjust for the 3Rs our MER is in line with our expectations, which is why, as I said in my remarks, that we are going to break even or better for 2015. That still is the case.

I was just saying, but the 3Rs clearly help us in that regard and it's higher than we anticipated for the reasons that we went through.

**Ana Gupte (Analyst - Leerink Partners):**

Okay. One final one, if I may. Then on Humana One, might you be in a place where you had some adverse selection last year, and as you are raising prices are you seeing more of a deterioration in that book? Because anyone who can afford or is relatively healthy migrates someplace else and so you might have challenges just turning around the book.

**Jim Murray (EVP, COO):**

As respect to the state of Georgia, which we've talked about a couple of times, I wouldn't have said that it was adverse selection as opposed to the health condition of the entire population. We just have to price reflective of the health condition and that may cause some of those members to move on to other plans. But we've got to get our pricing commensurate with the risk conditions that we are assuming.

And we think that we've got a pretty good plan in place not only to increase pricing, but also evaluate some of the products that are in the marketplace.

**Ana Gupte (Analyst - Leerink Partners):**

Great, thanks so much. Appreciate it.
Operator:

Christine Arnold, Cowen.

Christine Arnold (Analyst - Cowen and Company):

Thanks for taking the question. Trying to sort through what belongs in this year versus last year. Was there any net prior-period negative developments in the first quarter of this year related to last year in any products?

Brian Kane (SVP, CFO):

I’m not sure I understand the question. There was -- the prior-period development was positive this quarter based on 2014 and prior results. It was less positive than it was last first quarter in 2014.

That was largely expected for the reasons I discussed, i.e., it was a very high PPD quarter in the first quarter of 2014 and we implemented some claims processing changes with front-end review in Medicare that drove some of the change. Some of that was unexpected. So there is positive PPD in our numbers, just less than there was last year.

Christine Arnold (Analyst - Cowen and Company):

Okay. And then payables versus premiums, I agree we should exclude PDP. But if we exclude PDP premiums, your payables versus premiums are still upside down in the first quarter.

Now this could be because you’ve got more capitated costs. It could be because of other factors. Can you help me understand why?

If you are seeing an increase in utilization, I would think you would be booking more payables relative to premiums, plus these issues with the individual book. But it looks like that's not happening so can you help me sort through what other factors might be accounting for that?

Brian Kane (SVP, CFO):

That comparison, change of premium versus change in claims payables, as we've discussed in the past, is not something that we've focused on. There are a lot of moving pieces that go into that number.

As we’ve said with regard utilization, I wouldn’t have made the statement as boldly as you just made it with regard to overall utilization. What we have pointed out, because it's important that we point it out to be fully transparent, is that we have seen that slight increase in admits over the recent weeks and it's something that we are waiting to see how it plays through our claims lags over the coming months. As you know, it takes a few months for those to work through.

But I wouldn’t have made the overall statement that utilization is up. Remember that our admits are actually down year-over-year. Our trend vendors are working, as we have said, and so I wouldn't read into it anything more than that.

As you look for balance sheet quality and cash flow quality, the claims -- the processed claims and unprocessed claims on a DCP basis are actually up, which I know is a measure that you and others look at. And when you look at our cash flow for the year, which is where we focused because of the timing of these working capital issues that I went through, other than the 3Rs, and of course Concentra, we are actually reasonably line. As you know, we took up our cash flow last quarter and I think were it not for some of these other adjustments that I just discussed, we would be in pretty good stead there.

Bruce Broussard (President, CEO):
We appreciate the support the shareholders are providing us. We recognize that this quarter is a complicated quarter as a result of our Concentra sale, as a result of some of the changes in the comparison. But we do believe it is a quarter that continues to reconfirm the organization’s strategy around our growth in retail in addition to the integrated delivery model.

So in conclusion, as always, we thank our 60,000 associates that help us bring these results to life every day and we appreciate the shareholders' support. So thank you and we look forward to continuing our conversations later. Thank you.

Operator:

This concludes today's conference call.

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