UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2016
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (502) 580-1000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of exchange on which registered**
Common stock, $0.16 2/3 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2016 was $26,887,040,202 calculated using the average price on June 30, 2016 of $180.70.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2017 was 149,324,101.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 20, 2017.

HUMANA INC.
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For the Year Ended December 31, 2016

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Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. As of December 31, 2016, we had approximately 14.2 million members in our medical benefit plans, as well as approximately 7.0 million members in our specialty products. During 2016, 75% of our total premiums and services revenue were derived from contracts with the federal government, including 14% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 598,100 members as of December 31, 2016.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2016 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2016 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

On July 21, 2016, the U.S. Department of Justice and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders.Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year industry wide commercial reinsurance fee. The Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform" in this 2016 Form 10-K.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

Business Segments

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the

flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, home based, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2016:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 31,863	59.0%
Group Medicare Advantage	4,283	8.0%
Medicare stand-alone PDP	4,009	7.4%
Total Medicare	40,155	74.4%
Individual commercial	3,492	6.4%
State-based Medicaid	2,640	4.9%
Individual specialty	259	0.5%
Total premiums	46,546	86.2%
Services	8	—%
Total premiums and services revenue	$ 46,554	86.2%

Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part

C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage, or MA, plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017.

At December 31, 2016, we provided health insurance coverage under CMS contracts to approximately 2,837,600 individual Medicare Advantage members, including approximately 598,100 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.7 billion, which represented approximately 24.2% of our individual Medicare Advantage premiums revenue, or 14.0% of our consolidated premiums and services revenue for the year ended December 31, 2016.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2017, and all of our product offerings filed with CMS for 2017 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2017, and all of our product offerings filed with CMS for 2017 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

State-based Medicaid Contracts

Our state-based contracts allow us to serve members enrolled in state-based Medicaid programs including Temporary Assistance to Needy Families, or TANF, Long-Term Support Services, or LTSS, and dual eligible demonstration programs. TANF is a state and federally funded program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term support services for our members who receive home and community or institution-based services for long-term care. Our contracts are generally for three to five year terms.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. There were approximately 10.4 million dual eligible individuals in the United States in 2016, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and LTSS benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs.

We have contracts to serve Medicaid eligible members in Florida under the TANF and LTSS programs. Our contracts in Virginia and Illinois serve members under each state's stand-alone dual eligible demonstration program. In addition, in Illinois we have an Integrated Care Program, or ICP, Medicaid contract. Our Kentucky Medicaid contract is subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource.

In addition to the dual eligible members we serve under the Virginia and Illinois demonstration program, we serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans. As of December 31, 2016, we served approximately 486,000 dual eligible members in our Medicare Advantage plans and approximately 1,179,000 dual eligible members in our stand-alone prescription drug plans.

Individual Commercial Coverage

Our individual health plans are marketed under the HumanaOne brand. We offer products both on and off of the public exchange. We offer products on exchanges where we can achieve an affordable cost of care, including HMO offerings and select networks in most markets. Our off-exchange products are primarily PPO and POS offerings, including plans issued prior to 2014 that were previously underwritten. For 2017, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. Policies issued prior to the enactment of the Health Care Reform Law on March 23, 2010 are grandfathered policies. Grandfathered policies are exempt from most of the requirements of the Health Care Reform Law, including mandated benefits. However, our grandfathered plans include provisions that guarantee renewal of coverage for as long as the plan is continued and the individual chooses to renew. Policies issued between March 23, 2010 and December 31, 2013 are required to conform to the Health Care Reform Law, including mandated benefits, upon renewal at various transition dates between 2016 and 2017 depending on the state.

On February 14, 2017, we announced we are exiting our individual commercial medical businesses January 1, 2018 as more fully described in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Rewards-based wellness programs are included with many individual products. We also offer optional benefits such as dental, vision, life, and a portfolio of financial protection products.

Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans as well as health and wellness products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group segment by product for the year ended December 31, 2016:

	Group Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,405	10.0%
Group specialty	1,020	1.9%
Military services	12	—%
Total premiums	6,437	11.9%
Services	694	1.3%
Total premiums and services revenue	$ 7,131	13.2%
Intersegment services revenue:		
Wellness	$ 99	n/a
Total intersegment services revenue	$ 99	

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses. As with our individual commercial products, the employer group offerings include Go365™, our wellness and loyalty reward program.

Our administrative services only, or ASO, products are offered to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing substantially all of the cost of health benefits. However, more than half of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

As with individual commercial policies, employers can customize their offerings with optional benefits such as dental, vision, life, and a portfolio of voluntary benefit products.

Military Services

Under our TRICARE South Region contract with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. On April 1, 2012, we began delivering services under our current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. Under the current contract, we provide administrative services while the federal government

retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement.

Wellness

We offer wellness solutions including our Go365 wellness and loyalty rewards program, health coaching, employee assistance program, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Go365 program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual's needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

We also provide employee assistance programs and coaching services including a comprehensive turn-key coaching program, an enhancement to a medically based coaching protocol and a platform that makes coaching programs more efficient.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, home based services, clinical programs, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2016:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 21,952	n/a
Provider services	1,677	n/a
Home based services	1,026	n/a
Clinical programs	180	n/a
Total intersegment revenue	$ 24,835	
External services revenue:		
Pharmacy solutions	$ 31	0.1%
Provider services	78	0.1%
Home based services	148	0.3%
Total external services revenue	$ 257	0.5%

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through Humana Pharmacy, Inc., as well as research services.

Provider services

We operate full-service, multi-specialty medical centers, primarily in Florida, staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

We also operate Transcend, a Medical Services Organization, or MSO, that coordinates medical care for Medicare Advantage beneficiaries primarily in four states. Transcend provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Transcend collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions. Transcend represents a key component of our integrated care delivery model which we believe is scalable to new markets. In addition, we own a noncontrolling equity interest in MCCI Holdings, LLC, a privately held MSO headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida, Texas and Georgia.

Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We believe that technology represents a significant opportunity in health care that positively impacts our members. Our Transcend Insights business focuses on population health and wellness capabilities across the sector and serves health care systems, physicians and care teams by leveraging actionable data to help improve patient care. We help care teams and patients transition from a reactive approach to care to one that proactively promotes health and long-term wellness. We have enhanced our health information technology capabilities enabling us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, that delivered occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Home based services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Home based services include the operations of Humana At Home, Inc., or Humana At Home ®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. To that end, we have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2016, we enrolled approximately 622,300 members with complex chronic conditions in the Humana Chronic Care Program, a 5.4% increase compared with approximately 590,300 members at December 31, 2015, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Clinical programs

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management, behavioral health services and wellness programs.

Our care management programs take full advantage of the population health, wellness and clinical applications offered by Transcend Insights and CareHub, our clinical management tool used by providers and care managers across the company to help our members achieve their best health, to offer various levels of support, matching the intensity of the support to the needs of members with ongoing health challenges through telephonic and onsite programs. These programs include Personal Nurse, chronic condition management, and case management as well as programs supporting maternity, cancer, neonatal intensive care unit, and transplant services.

In addition, we focus on the behavioral aspects of a members' health such as managing stress and work/life balance. Humana Behavioral Health takes a holistic, mind-and-body approach to behavioral healthcare to address the whole person, encouraging faster recovery and improving clinical outcomes while reducing costs for both the member and employer.

Other Businesses

Other Businesses primarily includes our closed block of long-term care insurance policies described below. Total premiums and services revenue for our Other Businesses was $48 million, or 0.1% of consolidated premiums and services revenue for the year ended December 31, 2016.

We have a non-strategic closed block of approximately 30,800 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

Membership

The following table summarizes our total medical membership at December 31, 2016, by market and product:

	Retail Segment					Group Segment						
	(in thousands)											
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Individual Commercial	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Other Businesses	Total	Percent of Total
Florida	598.1	16.0	345.0	194.4	6.7	365.9	140.2	50.7	—	—	1,717.0	12.1%
Texas	222.5	69.9	309.7	101.4	7.5	—	203.1	24.6	—	—	938.7	6.6%
Kentucky	76.3	58.2	206.5	10.1	5.4	—	107.7	170.1	—	—	634.3	4.5%
Georgia	115.8	2.5	130.2	163.7	9.9	—	158.1	20.8	—	—	601.0	4.2%
California	70.0	0.1	444.3	—	15.7	—	—	—	—	—	530.1	3.7%
Ohio	118.2	16.3	181.8	5.8	48.5	—	51.0	69.1	—	—	490.7	3.4%
Illinois	87.8	21.3	174.7	5.4	4.4	11.5	72.8	89.9	—	—	467.8	3.3%
Missouri/Kansas	90.7	4.3	213.2	16.4	8.1	—	54.9	10.8	—	—	398.4	2.8%
North Carolina	146.4	39.5	178.3	2.6	4.7	—	—	—	—	—	371.5	2.6%
Tennessee	144.9	3.7	108.6	27.9	4.0	—	46.7	29.4	—	—	365.2	2.6%
Louisiana	155.9	11.5	58.2	29.2	1.6	—	68.6	32.9	—	—	357.9	2.5%
Wisconsin	63.2	10.6	113.0	5.9	5.0	—	89.0	37.2	—	—	323.9	2.3%
Virginia	112.3	6.1	140.3	1.4	7.9	10.7	—	—	—	—	278.7	2.0%
Indiana	93.1	3.7	133.3	2.1	7.5	—	22.8	14.2	—	—	276.7	1.9%
Michigan	47.4	14.0	147.6	27.2	2.9	—	5.3	0.5	—	—	244.9	1.7%
Pennsylvania	40.3	0.9	157.4	—	4.6	—	—	—	—	—	203.2	1.4%
South Carolina	95.0	0.8	86.0	0.2	4.7	—	—	—	—	—	186.7	1.3%
Military services	—	—	—	—	—	—	—	—	3,084.1	—	3,084.1	21.7%
Others	559.7	76.0	1,823.3	61.1	69.7	—	115.8	23.0	—	30.8	2,759.4	19.4%
Totals	2,837.6	355.4	4,951.4	654.8	218.8	388.1	1,136.0	573.2	3,084.1	30.8	14,230.2	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate or diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Automatic reductions to the federal budget, known as sequestration, took effect on April 1, 2013, including aggregate reductions to Medicare payments to providers of up to 2% per fiscal year. Due to the uncertainty around the application of these reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2016, approximately 1,193,400 members, or 8.4% of our medical membership, were covered under risk-based contracts, including 921,000 individual Medicare Advantage members, or 32.5% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 191,300 HMO members, including 170,500 individual Medicare Advantage members, or 18.5% of the 921,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2016, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.3 billion, or 2.9% of total benefits expense, for the year ended December 31, 2016. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or the Joint Commission on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee, composed of a peer group of providers, reviews the applications of providers being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care, and URAC. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Additionally, all products sold on the federal and state marketplaces are required to be accredited. Certain commercial businesses, like those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in most of our commercial, Medicare and Medicaid HMO/POS markets with enough history and membership, and for many of our PPO markets.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2016, we employed approximately 1,500 sales representatives, as well as approximately 1,300 telemarketing representatives who assisted in the marketing of Medicare and individual commercial health insurance

and specialty products in our Retail segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. In addition, we have begun to offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange where employees can shop for a health plan and other benefits based on what the employer has selected as options. We use licensed independent brokers, independent agents, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our individual commercial health insurance and specialty products.

Underwriting

Since 2014, the Health Care Reform Law requires all individual and certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, newly issued individual and certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2016 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2016 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service. Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

Employees

As of December 31, 2016, we had approximately 51,600 employees and approximately 2,600 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to the Terminated Merger with Aetna

Our proposed merger with Aetna has affected and may in the future, materially and adversely affect our results of operations and stock price.

On February 14, 2017, we and Aetna agreed to mutually terminate our Merger Agreement, as our Board determined that an appeal of the Court's ruling enjoining the transaction would not be in the best interest of our stockholders. Although difficult to quantify, we believe that the proposed merger with Aetna, and subsequent termination of the Merger Agreement, has affected and may, in the future, materially and adversely affect our results of operations, due to the following:

- continued liability for certain transaction costs, including legal, accounting, financial advisory and other costs relating to the transaction;
- diverted management attention to the transaction and integration planning efforts;
- disruption of our business due to member uncertainty over when or if the acquisition will be completed or members' perception of us as a standalone company, our perception among and activities by external brokers, as well as our ability to negotiate and maintain relationships with certain providers in our network;
- certain restrictions in the Merger Agreement on the conduct of our business prior to its termination; and
- other uncertainties that have impaired our ability to retain, recruit and motivate key personnel.

The occurrence, continuation or exacerbation of any of these events individually or in combination could materially and adversely affect our results of operations.

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. We continually review these estimates, however these estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Any reserve, including a premium deficiency reserve, may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;

- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from the Health Care Reform Law.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

In addition, we also estimate costs associated with long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental insurance policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. Our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. However, to the extent premium rate increases or loss experience vary from the assumptions we have locked in, additional future adjustments to reserves could be required.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, any costs associated with exiting products, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, participation in health insurance exchanges, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee and other assessments under the Health Care Reform Law), and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable, or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We may also face increased competition due to participation by other insurers in the health insurance exchanges implemented under the Health Care Reform Law. We believe that barriers to entry

in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

The policies and decisions of the federal and state governments regarding the Medicare, military, Medicaid and health insurance exchange programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives, our state-based contracts strategy, and our participation in the new health insurance exchanges, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model, our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs, and our participation in health insurance exchanges.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 74% of our total premiums and services revenue for the year ended December 31, 2016 generated from our Medicare products, including 14% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives

to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

Additionally, our strategy includes the growth of our commercial products, including participation in certain health insurance exchanges, introduction of new products and benefit designs, including Go365 and other wellness products, growth of our specialty products such as dental, vision and other supplemental products, the adoption of new technologies, development of adjacent businesses, and the integration of acquired businesses and contracts.

There can be no assurance that we will be able to successfully implement our operational and strategic initiatives, including implementing our integrated care delivery model, that are intended to position us for future growth or that the products we design will be accepted or adopted in the time periods assumed. Failure to implement this strategy may result in a material adverse effect on our results of operations, financial position, and cash flows.

There can be no assurances that we will be successful in maintaining or improving our Star ratings in future years. In addition, there can be no guarantees that the reconsideration that we filed with respect to certain of our Star rating measures for the 2018 bonus year will be successful, that operational measures we may take will successfully mitigate any negative effects of Star quality ratings for the 2018 bonus year or future years, or that we will not experience a decline in membership growth for 2018 as a result of our 2018 bonus year Star ratings.

The achievement of Star ratings of 4-Star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

On October 12, 2016, CMS published updated Star quality ratings for the 2018 bonus year, which showed that the percentage of our July 31, 2016 Medicare Advantage membership in 4-Star plans or higher had declined to approximately 37 percent from approximately 78 percent of our July 31, 2015 Medicare Advantage membership. This decline in membership in 4-Star rated plans does not take into account certain operational actions we intend to take over the coming quarters to mitigate any potential negative impact of these published ratings on Star bonus revenues for 2018. Moreover, we expect the impact of CMS' comprehensive program audit on our Star ratings to be limited to the 2018 bonus year, and Star results for the 2018 bonus year are not expected to materially impact our Medicare revenue for 2017.

We believe that our Star ratings for the 2018 bonus year do not accurately reflect our actual performance under the applicable Star measures. Consequently, we have filed for reconsideration of certain of those ratings by CMS under the appropriate administrative process.

There can be no guarantees, however, that the request for reconsideration that we filed with CMS will be successful, that any operational measures we may take will successfully mitigate all negative effects of our Star quality ratings for the 2018 bonus year, which could be material, or that we will not experience a decline in membership growth for 2018 as a result of our 2018 bonus year Star ratings.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and

enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment and employment discrimination-related suits, employee benefit claims, stockholder suits and other securities laws claims, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts or provider contract disputes relating to rate adjustments resulting from the Balance Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration");
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;
- claims relating to dispensing of drugs associated with our in-house mail-order pharmacy; and
- professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought.

While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require

us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 75% of our total premiums and services revenue for the year ended December 31, 2016. These programs involve various risks, as described further below.

- At December 31, 2016, under our contracts with CMS we provided health insurance coverage to approximately 598,100 individual Medicare Advantage members in Florida. These contracts accounted for approximately 14% of our total premiums and services revenue for the year ended December 31, 2016. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2016, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3,084,100 beneficiaries. For the year ended December 31, 2016, premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 1% of our total premiums and services revenue. On April 1, 2012, we began delivering services under the current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On March 30, 2016, we received notice that the DHA exercised its option to extend the TRICARE South Region contract through March 31, 2017. On July 21, 2016, we were notified by the DHA that we were awarded the contract for the new TRICARE East Region, which is a consolidation of the former North and South Regions, with delivery of health care services expected to commence on October 1, 2017. The next generation East Region and West Region contract awards are currently subject to protests by unsuccessful bidders in the U.S. Court of Federal Claims and before the DHA. The loss of the TRICARE South Region contract or an overturn of the award of the East Region contract to us, should either occur, may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical

diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013, in which two, five, and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of

these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $150 million at December 31, 2016.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the applicable year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market

or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 could have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with a non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

For additional information, please refer to the section entitled, "Health Care Reform" in "Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing in this annual report.

Our continued participation in the federal and state health insurance exchanges, which entail uncertainties associated with mix, volume of business and the operation of premium stabilization programs, which are subject to federal administrative action, could adversely affect our results of operations, financial position, and cash flows.

The Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. The risk corridor program is a three-

year program, and the Department of Health and Human Services (HHS) guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off our risk corridor receivables. In addition, other regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange.

For 2017, we are offering on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans in 2017. Despite this reduction in our individual commercial membership plans, the above factors, in addition to competitor actions to withdraw from exchanges and/or alter their product offerings, may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. In addition, audits of our submissions under the risk adjustment program may result in repayment of amounts distributed under the program. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows, and we may be unable to adjust our product offerings, geographic footprint, or pricing during any given year in sufficient time to mitigate any such effects.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, including reductions in Medicare Advantage payment rates, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

In addition to the Health Care Reform Law, the health care industry in general and health insurance are subject to substantial federal and state government regulation:

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act and HIPAA mandate individual notification in the event of a breach of unsecured, individually identifiable health information,

provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires HHS to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended

prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which

may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. The divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. There can be no assurance that we will be able to complete any such divestitures on terms favorable to us.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected.

We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of

prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The U.S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2016:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	129	—	87	227
Texas	—	16	2	17	35
Kentucky	2	1	11	12	26
Arizona	—	10	—	6	16
Virginia	—	8	—	8	16
California	—	2	—	13	15
South Carolina	—	6	4	5	15
Illinois	—	5	—	9	14
Louisiana	—	4	—	10	14
New York	—	—	—	13	13
Ohio	—	1	—	11	12
Indiana	—	4	—	7	11
Nevada	—	6	—	5	11
Tennessee	—	—	—	11	11
Colorado	—	5	—	4	9
Georgia	—	5	—	3	8
New Jersey	—	—	—	8	8
Washington	—	4	—	4	8
Puerto Rico	—	—	—	7	7
Michigan	—	2	—	4	6
North Carolina	—	—	—	6	6
Others	—	—	1	46	47
Total	13	208	18	296	535

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of the medical centers included in the table above, approximately 67 of these facilities are leased or subleased to our contracted providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used

for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2016 and 2015:

	High	Low
Year Ended December 31, 2016		
First quarter	$ 186.91	$ 156.96
Second quarter	$ 190.07	$ 165.23
Third quarter	$ 180.86	$ 153.38
Fourth quarter	$ 216.76	$ 165.31
Year Ended December 31, 2015		
First quarter	$ 182.79	$ 139.09
Second quarter	$ 214.92	$ 163.07
Third quarter	$ 193.14	$ 174.16
Fourth quarter	$ 186.67	$ 164.25

Holders of our Capital Stock

As of January 31, 2017, there were approximately 2,700 holders of record of our common stock and approximately 92,300 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2015 and 2016, under our Board approved quarterly cash dividend policy:

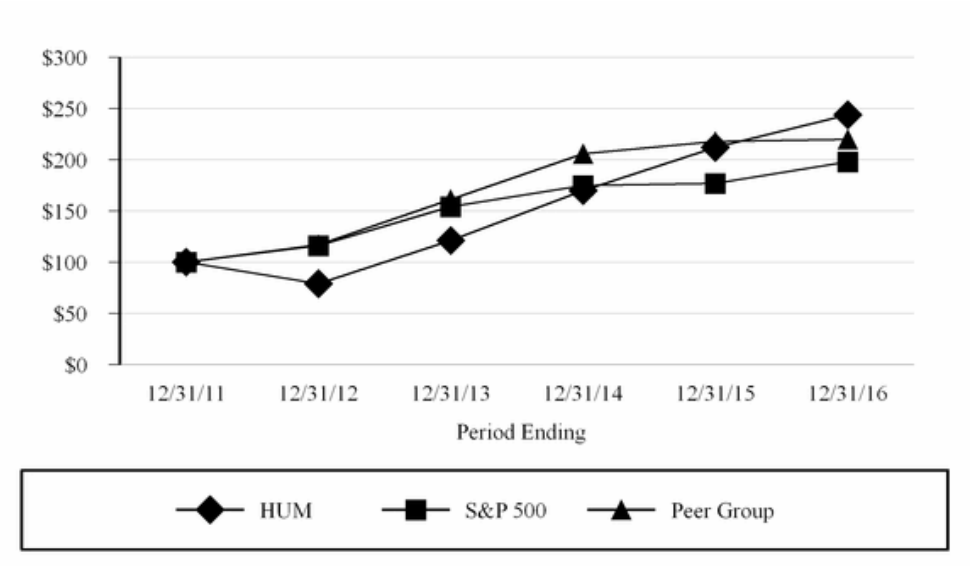
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2015 payments			
12/31/2014	1/30/2015	$0.28	$42
3/31/2015	4/24/2015	$0.28	$42
6/30/2015	7/31/2015	$0.29	$43
9/30/2015	10/30/2015	$0.29	$43
2016 payments			
12/30/2015	1/29/2016	$0.29	$43
3/31/2016	4/29/2016	$0.29	$43
6/30/2016	7/29/2016	$0.29	$43
10/13/2016	10/28/2016	$0.29	$43

Under the terms of the Merger Agreement, we agreed with Aetna that our quarterly dividend would not exceed $0.29 per share prior to the closing or termination of the Merger. On October 26, 2016, the Board declared a cash dividend of $0.29 per share that was paid on January 27, 2017 to stockholders of record on January 12, 2017, for an aggregate amount of $43 million.

On February 14, 2017, following the termination of the Merger Agreement, the Board declared a cash dividend of $0.40 per share, to be paid on April 28, 2017, to the stockholders of record on March 31, 2017. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2016. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2011, and that dividends were reinvested when paid.



	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016
HUM	$ 100	$ 79	$ 121	$ 170	$ 212	$ 244
S&P 500	$ 100	$ 116	$ 154	$ 175	$ 177	$ 198
Peer Group	$ 100	$ 117	$ 161	$ 206	$ 218	$ 220

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table indicates that we made no purchases during the three months ended December 31, 2016 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)(2)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
October 2016	—	$ —	—	$ —
November 2016	—	—	—	—
December 2016	—	—	—	—
Total	—	$ —	—	

(1) In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion with an authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, which expired on December 31, 2016. Pursuant to the Merger Agreement, after July 2, 2015, we were prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we suspended our share repurchase program.

(2) Excludes 0.6 million shares repurchased in connection with employee stock plans.

The Merger Agreement included customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend would not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program). On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. Under this new authorization, we expect to complete a $1.5 billion accelerated share repurchase program in the first quarter of 2017.

ITEM 6. SELECTED FINANCIAL DATA

	2016 (a)	2015 (b)(c)	2014 (b)(d)	2013 (b)(e)	2012 (b)(f)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 53,021	$ 52,409	$ 45,959	$ 38,829	$ 37,009
Services	969	1,406	2,164	2,109	1,726
Investment income	389	474	377	375	391
Total revenues	54,379	54,289	48,500	41,313	39,126
Operating expenses:					
Benefits	45,007	44,269	38,166	32,564	30,985
Operating costs	7,277	7,318	7,639	6,355	5,830
Depreciation and amortization	354	355	333	333	295
Total operating expenses	52,638	51,942	46,138	39,252	37,110
Income from operations	1,741	2,347	2,362	2,061	2,016
Gain on sale of business	—	270	—	—	—
Interest expense	189	186	192	140	105
Income before income taxes	1,552	2,431	2,170	1,921	1,911
Provision for income taxes	938	1,155	1,023	690	689
Net income	$ 614	$ 1,276	$ 1,147	$ 1,231	$ 1,222
Basic earnings per common share	$ 4.11	$ 8.54	$ 7.44	$ 7.81	$ 7.56
Diluted earnings per common share	$ 4.07	$ 8.44	$ 7.36	$ 7.73	$ 7.47
Dividends declared per common share	$ 1.16	$ 1.15	$ 1.11	$ 1.07	$ 1.03
Financial Position:					
Cash and investments	$ 13,675	$ 11,681	$ 11,482	$ 10,938	$ 11,153
Total assets	25,396	24,678	23,497	20,719	19,962
Benefits payable	4,563	4,976	4,475	3,893	3,779
Debt	4,092	4,093	3,795	2,584	2,594
Stockholders' equity	10,685	10,346	9,646	9,316	8,847
Cash flows from operations	$ 1,936	$ 868	$ 1,618	$ 1,716	$ 1,923
Key Financial Indicators:					
Benefit ratio	84.9%	84.5%	83.0%	83.9%	83.7%
Operating cost ratio	13.5%	13.6%	15.9%	15.5%	15.1%
Membership by Segment:					
Retail segment:					
Medical membership	9,406,100	9,226,800	8,376,500	6,459,300	5,956,700
Specialty membership	1,088,100	1,153,100	1,165,800	1,042,500	948,700
Group segment:					
Medical membership	4,793,300	4,963,400	5,430,200	5,501,600	5,573,400
Specialty membership	5,873,100	6,068,700	6,502,700	6,780,800	7,136,200
Other Businesses:					
Medical membership	30,800	32,600	35,000	23,400	558,700
Consolidated:					
Total medical membership	14,230,200	14,222,800	13,841,700	11,984,300	12,088,800
Total specialty membership	6,961,200	7,221,800	7,668,500	7,823,300	8,084,900

(a) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies. In addition, we recorded transaction and integration planning costs in connection with the Merger of approximately $104 million, or $0.64 per diluted common share.

(b) Debt for prior periods has been recast to conform to the 2016 presentation which presents debt issuance cost as a direct reduction of the related liability instead of an asset.

(c) Includes a gain on the sale of Concentra Inc., net of transaction costs, of $270 million ($238 million after tax, or $1.57 per diluted common share). Also includes benefits expense of $176 million ($112 million after tax, or $0.74 per diluted common share) for a provision for probable

future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year.

(d) Includes loss on extinguishment of debt of $37 million ($23 million after tax, or $0.15 per diluted common share) for the redemption of senior notes.

(e) Includes benefits expense of $243 million ($154 million after tax, or $0.99 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

(f) Includes the acquired operations of Arcadian Management Services, Inc. from March 31, 2012, SeniorBridge Family Companies, Inc. from July 6, 2012, and Metropolitan Health Networks, Inc. from December 21, 2012.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, excluding depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

On July 21, 2016, the U.S. Department of Justice and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Business Segments

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts, as well as individual commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products. In addition, the Retail segment also includes our contract

with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Group segment consists of employer group commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products. In addition, our Group segment includes our health and wellness products (primarily marketed to employer groups) and military services business, primarily our TRICARE South Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, home based services, and clinical programs, as well as services and capabilities to advance population health. We will continue to report under the category of Other Businesses those businesses which do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

The results of each segment are measured by income before income taxes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low-income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

Our Group segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses. Similarly, certain of our fully-insured individual commercial medical products in our Retail segment experience seasonality in the benefit ratio akin to the Group segment, including the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers. As previously underwritten members transition, it results in policy lapses and the release of reserves for future policy benefits partially offset by the recognition of previously deferred acquisition costs. These policy lapses generally occur during the first quarter of the new coverage year following the open enrollment period reducing the benefit ratio in the first quarter. The recognition of a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law in the fourth quarter of 2015, and subsequent changes in estimates, also impact the quarterly benefit ratio pattern for this business in 2016 and 2015.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare and individual health care exchange marketing seasons.

Highlights

Consolidated

- On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. Under this new authorization, we expect to complete a $1.5 billion accelerated share repurchase program in the first quarter of 2017. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

- Our 2016 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2016, approximately 1,816,300 members, or 64.0%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,633,100 members, or 59.3%, at December 31, 2015.

- On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million ($367 million after-tax, or $2.43 per diluted common share) in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. At December 31, 2016, we estimate that we are entitled to collect a total of $619 million from HHS under the commercial risk corridor program for the 2014 through 2016 program years.

- In the fourth quarter of 2016, we increased the future policy benefits expense by approximately $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies.

- As discussed in the Retail segment highlights that follow, during 2015, we recognized a premium deficiency reserve of approximately $176 million for certain of our individual commercial medical products for the 2016 coverage year. During 2016, we increased this premium deficiency reserve associated with the 2016 coverage year by $208 million, or $0.87 per diluted common share.

- During 2016, we recorded transaction and integration planning costs in connection with the Merger of approximately $104 million, or $0.64 per diluted common share. During 2015, we recorded transaction costs in connection with the Merger of approximately $23 million, or $0.14 per diluted common share. Certain costs associated with the transaction were not deductible for tax purposes.

- On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million, or $1.57 per diluted common share in 2015.

- Excluding the impact of the risk corridor receivables write-off, the long-term care reserve strengthening, the premium deficiency reserve recorded for the 2016 coverage year, and the sale of Concentra in 2015, the increase in pretax income primarily was due to year-over-year improvements in results for our individual Medicare Advantage business and Healthcare Services segment as well as increased profitability in our state-based contracts business.

- Year-over-year comparisons of the operating cost ratio are impacted by the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio than our Group and Retail segments. This was partially offset by the risk corridor receivables write-off.

- Investment income decreased $85 million in 2016, primarily due to lower realized capital gains in 2016 and lower interest rates partially offset by a higher average invested balance.

- As disclosed in Note 2 to the consolidated financial statements included in this report, we elected to early adopt new accounting guidance related to accounting for employee share-based payments, which changes how income tax effects of employee share-based payments are recorded. We adopted this guidance prospectively effective January 1, 2016. The adoption of this new guidance resulted in the recognition of approximately $20 million of tax benefits in net income, or $0.12 per diluted common share, in the first quarter of 2016.

- Operating cash flow provided by operations was $1.9 billion for the year ended December 31, 2016 as compared to operating cash flow provided by operations of $868 million for the year ended December 31, 2015. The increase in operating cash flow primarily was due to significantly favorable working capital items and higher earnings exclusive of the commercial risk corridor receivables write-off and the long-term care reserve strengthening in 2016, as well as the gain on sale of Concentra and the recognition of the premium deficiency reserve in 2015 discussed previously. The working capital changes year-over-year primarily reflect lower income tax payments, changes in the net receivable balance associated with the premium stabilization programs established under health care reform, or the 3R's, and the timing of payroll cycles resulting in one less payroll cycle in 2016, partially offset by the timing of payments for benefits expense.

- In 2016, we paid the federal government $916 million for the annual non-deductible health insurance industry fee compared to our payment of $867 million in 2015. This fee is not deductible for tax purposes, which significantly increased our effective income tax rate beginning in 2014. The health insurance industry fee is further described below under the section titled "Health Care Reform." The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This suspension will significantly reduce our operating costs and effective tax rate in 2017. Our effective tax rate for 2017 is expected to be approximately 36% to 37%. The decline in the effective tax rate primarily is due to the suspension of the annual health insurance industry fee in 2017.

- We paid dividends to stockholders of $177 million in 2016 as compared to $172 million in 2015.

Retail Segment

- On February 1, 2017, CMS issued its preliminary 2018 Medicare Advantage and Part D payment rates and proposed policy changes, which we refer to collectively as the Advance Notice. CMS has invited public comment on the Advance Notice before publishing final rates on April 3, 2017 (the Final Notice). In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 0.25 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. CMS' estimate

includes 40 basis points of negative impact associated with Star quality bonuses sector-wide. Excluding that item, CMS' estimate would be a 0.65 percent increase. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS' website, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate, excluding the impact attributable to Star quality bonuses. We believe we can design our 2018 Medicare Advantage plan filings, including the applicable level of rate changes, to remain competitive compared to both the combination of original Medicare with a supplement policy and Medicare Advantage products offered by our competitors. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

- The achievement of Star Ratings of four or higher qualifies Medicare Advantage plans for premium bonuses. Star Ratings for the 2018 bonus year issued by CMS in October 2016 indicated that the percentage of our July 31, 2016 Medicare Advantage membership in 4-Star plans or higher declined to approximately 37% from approximately 78% of our July 31, 2015 Medicare Advantage membership. The decline in membership in 4-Star rated plans does not take into account certain operational actions discussed below that we have taken and intend to take over the coming months to mitigate any potential negative impact of these published ratings on Star bonus revenues for 2018.

  We believe that the decline is primarily attributable to the impact of lower scores for certain Stars measures as a result of our 2015 comprehensive program audit by CMS. The Civil Monetary Penalty imposed by CMS following the audit resulted in a significant reduction to the Beneficiary Access and Plan Performance, or BAPP, measure. Additionally, an issue with the timeliness of appeal decisions noted in the audit resulted in automatic downgrades to two additional Star measures. Moreover, higher threshold levels for certain individual Star measures as compared to the previous year reduced our ratings on these measures. Thresholds for Star measures are calculated across the sector, without regard to weighted average membership of each plan. Together, these factors more than offset our improved Star rating performance in certain quality measures such as Healthcare Effectiveness Data and Information, or HEDIS.

  Our Healthcare Effectiveness Data and Information Set, or HEDIS, measures, demonstrating the achievement of clinical outcomes, are at record-high results for the company. Accordingly, we believe that our Star ratings for the 2018 bonus year do not accurately reflect our actual performance under certain Star measures. Consequently, we filed for reconsideration of certain of those ratings under the appropriate administrative process. We are also evaluating our contract structures for rationalization to mitigate the negative impact on Star bonus revenues for 2018.

  The ultimate financial impact to us related to 2018 Star bonus revenues is dependent upon multiple variables including, but not limited to, the number of Medicare Advantage members in 4-Star or higher rated plans and the geographic distribution of those members as well as a number of operational initiatives which would serve to mitigate the negative impact of our Star performance. Star results for the 2018 bonus year are not expected to materially impact our Medicare revenue for 2017 but could be material to 2018 Medicare revenues.

- In 2016, our Retail segment pretax income increased by $7 million, or 0.8%, from 2015 primarily driven by the year-over-year improvement in our individual Medicare Advantage and state-based Medicaid businesses along with the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 associated with certain individual commercial medical policies for the 2016 coverage year. These items were substantially offset by the write-off of commercial risk corridor receivables as described further below and in the results of operations discussion that follows.

- Our Medicare Advantage results improved year-over-year primarily due to lower utilization and favorable year-over-year comparisons of prior-period medical claims reserve development. Operational initiatives are centered around optimizing the performance of our clinical programs to reduce medical cost trend. In addition our Medicare Advantage membership increased year-over-year as discussed below.

- Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the

passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 that we believed would improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results that included the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment in the fourth quarter of 2015 of the profitability of our individual commercial medical policies compliant with the Health Care Reform Law, we recorded in that quarter a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million, or $0.74 per diluted common share. In 2016, we increased the premium deficiency reserve for the 2016 coverage year by $208 million, primarily as a result of unfavorable current and projected claims experience at that time. As of December 31, 2016, we had no remaining premium deficiency reserve.

For 2017, we are offering on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. Our 2017 geographic presence for our individual commercial medical offerings covers 156 counties, down from our 2016 presence in 1,351 counties (covering both on-exchange and off-exchange offerings). Given recent competitor actions, including market exits resulting in the automatic assignment of members to our plans, as well as sales and renewal results from the open enrollment process, we now expect 2017 premiums associated with Health Care Reform Law compliant offerings to be in the range of $850 million to $900 million. By comparison, our full year 2016 premiums associated with Health Care Reform Law compliant offerings were $3.3 billion. The decrease from 2016 results reflects the adjustment to our geographic presence and product discontinuances, erosion of competitive position, partially offset by premium increases as well as the projected impact of certain competitor actions.

On February 14, 2017, we announced we are exiting our individual commercial medical businesses January 1, 2018. As discussed previously, we have worked over the past several years to address market and programmatic challenges in order to keep coverage options available wherever we could offer a viable product. This has included pursuing business changes, such as modifying networks, restructuring product offerings, reducing the company's geographic footprint and increasing premiums. All of these actions were taken with the expectation that our individual commercial medical business would stabilize to the point where we could continue to participate in the program. However, based on our initial analysis of data associated with our healthcare exchange membership following the 2017 open enrollment period, we are seeing further signs of an unbalanced risk pool. Therefore, we have decided that we cannot continue to offer this coverage for 2018.

- Individual Medicare Advantage membership of 2,837,600 at December 31, 2016 increased 84,200 members, or 3.1%, from 2,753,400 at December 31, 2015 reflecting net membership additions, particularly for our Medicare Advantage Health Maintenance Organization, or HMO, offerings. January 2017 individual Medicare Advantage membership approximated 2,848,000, increasing approximately 10,400 members from December 31, 2016 reflecting net membership additions during the recently completed Annual Election Period for Medicare beneficiaries, including the loss of approximately 50,000 members in plans no longer offered for 2017. For full year 2017, we anticipate net membership growth in our individual Medicare Advantage offerings of 30,000 to 40,000.
- Group Medicare Advantage membership of 355,400 at December 31, 2016 decreased 128,700 members, or 26.6%, from 484,100 at December 31, 2015 primarily reflecting the loss of a large account that moved to a private exchange offering on January 1, 2016. January 2017 group Medicare Advantage membership approximated 431,000, increasing approximately 75,600 members, or 21%, from December 31, 2016 reflecting net membership additions during the recently completed Annual Election Period for Medicare beneficiaries.

For full year 2017, we expect net membership growth in our Group Medicare Advantage offerings of 70,000 to 80,000.

- Medicare stand-alone PDP membership of 4,951,400 at December 31, 2016 increased 393,500 members, or 8.6%, from 4,557,900 at December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2016 plan year. January 2017 Medicare stand-alone PDP membership (excluding transitional growth from the LI-NET prescription drug plan program) increased approximately 222,600 members, or 4%, from December 31, 2016 to 5,174,000 members reflecting net membership additions during the recently completed Annual Election Period for Medicare beneficiaries. For full year 2017, we anticipate net membership growth in our Medicare stand-alone PDP offerings of 320,000 to 340,000.
- Our state-based Medicaid membership of 388,100 at December 31, 2016 increased 14,400 members, or 3.9%, from 373,700 at December 31, 2015 primarily driven by the addition of members under our Florida Medicaid contract.
- Individual commercial medical membership of 654,800 at December 31, 2016 decreased 244,300 members, or 27.2%, from 899,100 at December 31, 2015 primarily reflecting the loss of on-exchange members due to product competitiveness, the loss of membership associated with the discontinuance of certain Health Care Reform Law compliant plans in 2016, the loss of membership associated with non-payment of premiums or termination by CMS due to lack of eligibility documentation, and the loss of members subscribing to plans that are not compliant with the Health Care Reform Law. At December 31, 2016, individual commercial medical membership in plans compliant with the Health Care Reform Law, both on-exchange and off-exchange, was 580,100 members, a decrease of 177,800 members or 23.5% from December 31, 2015.

  January 2017 individual commercial medical membership approximated 204,000, including 152,000 enrolled in plans compliant with the Health Care Reform Law. The decline of approximately 450,800 members, or 69%, from December 31, 2016 reflects net membership declines during the on-going open enrollment period for healthcare exchanges and the impact of product and service area reductions.

Group Segment

- Group segment pretax income for the year ended December 31, 2016 was essentially unchanged from the year ended December 31, 2015 as discussed in the results of operations discussion that follows.
- On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the TRICARE East Region contract, with delivery of health care services expected to commence on October 1, 2017. The new East Region is a combination of the current North Region and South Region. The next generation East Region and West Region contract awards are currently subject to protests by unsuccessful bidders in the U.S. Court of Federal Claims and before the DHA. Our current TRICARE South Region contract expires March 31, 2017.
- Membership in Go365™ (known as HumanaVitality® prior to January 2017), our wellness and loyalty rewards program, declined 7.2% to 3,649,100 at December 31, 2016 from 3,932,300 at December 31, 2015 reflecting a decline in group Medicare Advantage membership from the loss of the large account on January 1, 2016 and a decline in individual commercial medical membership.

Healthcare Services Segment

- Year-over-year comparisons of results of operations are impacted by the completion of the sale of Concentra on June 1, 2015.

- As discussed in the detailed Healthcare Services segment results of operations discussion that follows, our Healthcare Services segment pretax income increased $86 million, or 8.8%, for the year ended December 31, 2016. This increase was primarily due to incremental earnings associated with revenue growth from our pharmacy solutions business as it increased mail-order penetration and served our growing individual Medicare membership, partially offset by ongoing pressures in our provider services business reflecting significantly lower Medicare rates year-over-year associated with CMS' risk coding recalibration for 2016 in geographies where our provider assets are primarily located.
- Programs to enhance the quality of care for members are key elements of our integrated care delivery model. At December 31, 2016, we enrolled approximately 622,300 Medicare Advantage members with complex chronic conditions in the Humana Chronic Care Program, a 5.4% increase compared with approximately 590,300 members at December 31, 2015, reflecting a greater focus on members living with the most chronic conditions. Enhanced predictive modeling capabilities and proactive clinical outreach and engagement of those members helped drive increased clinical program participation, offset by the loss of engaged members associated with the group Medicare Advantage account that termed on January 1, 2016 as discussed previously. We continue to refine our clinical management programs to help optimize the quality of healthcare for our members and ensure appropriate returns on our investments.

Other Businesses

- As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry was $8 billion in 2014 and $11.3 billion in each of 2015 and 2016, with increasing annual amounts starting in 2018, and is not deductible for income tax purposes, which significantly increased our effective income tax rate. Our effective tax rate for 2016 was approximately 60.5%. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This suspension will significantly reduce our operating costs and effective tax rate in 2017. Our effective tax rate for 2017 is expected to be approximately 36% to 37%. The decline in the effective tax rate primarily is due to the suspension of the annual health insurance industry fee in 2017. The health insurance industry fee levied on the insurance industry was previously expected to be $14 billion in 2017. In 2016, we paid the federal government $916 million for the annual health insurance industry fee, a 5.7% increase from $867 million in 2015, primarily reflecting growth in our market share.

In addition, the Health Care Reform Law expands federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this 2016 Form 10-K.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits

and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products, and audits of our submissions under these programs may result in returns of funds distributed. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange. In addition, states may impose restrictions on our ability to increase rates. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows and could impact our decision to participate or continue in the program in certain states. For 2017, we are offering on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur. We may be unable to adjust our product offerings, geographic footprint, or pricing during any given year such legislative changes occur in sufficient time to mitigate any adverse effects.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows (including the delayed receipt of amounts due under the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law).

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2016, we collected approximately $36 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Comparison of Results of Operations for 2016 and 2015

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2016 and 2015:

Consolidated

	2016	2015	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 46,546	$ 45,805	$ 741	1.6 %
Group	6,437	6,569	(132)	(2.0)%
Other Businesses	38	35	3	8.6 %
Total premiums	53,021	52,409	612	1.2 %
Services:				
Retail	8	9	(1)	(11.1)%
Group	694	698	(4)	(0.6)%
Healthcare Services	257	685	(428)	(62.5)%
Other Businesses	10	14	(4)	(28.6)%
Total services	969	1,406	(437)	(31.1)%
Investment income	389	474	(85)	(17.9)%
Total revenues	54,379	54,289	90	0.2 %
Operating expenses:				
Benefits	45,007	44,269	738	1.7 %
Operating costs	7,277	7,318	(41)	(0.6)%
Depreciation and amortization	354	355	(1)	(0.3)%
Total operating expenses	52,638	51,942	696	1.3 %
Income from operations	1,741	2,347	(606)	(25.8)%
Gain on sale of business	—	270	(270)	100.0 %
Interest expense	189	186	3	1.6 %
Income before income taxes	1,552	2,431	(879)	(36.2)%
Provision for income taxes	938	1,155	(217)	(18.8)%
Net income	$ 614	$ 1,276	$ (662)	(51.9)%
Diluted earnings per common share	$ 4.07	$ 8.44	$ (4.37)	(51.8)%
Benefit ratio (a)	84.9%	84.5%		0.4 %
Operating cost ratio (b)	13.5%	13.6%		(0.1)%
Effective tax rate	60.5%	47.5%		13.0 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income for 2016 was $614 million, or $4.07 per diluted common share, in 2016 compared to $1.3 billion, or $8.44 per diluted common share, in 2015. Net income includes a write-off of $2.43 per diluted common share in

receivables associated with the commercial risk corridor premium stabilization program and reserve strengthening for our non-strategic closed block of long-term care insurance business o f $2.11 per diluted common share, as discussed below. These items were partially offset by the impact of the premium deficiency reserve of $0.74 per diluted common share recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. In addition, the completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain of $1.57 per diluted common share in 2015. Excluding these items, the increase primarily was due to year-over-year improvement in results for our individual Medicare Advantage business and our Healthcare Services segment as well as increased profitability in our state-based Medicaid business, partially offset by an increase in the effective tax rate as discussed below. In addition, 2016 includes expenses of $0.64 per diluted common share and 2015 includes expenses of $0.14 per diluted common share for transaction and integration planning costs associated with the Merger, certain of which were not deductible for tax purposes.

Premiums Revenue

Consolidated premiums increased $612 million, or 1.2%, from 2015 to $53.0 billion for 2016 primarily reflecting higher premiums in the Retail segment mainly driven by average membership growth and per member premium increases for certain of our lines of business. These increases were partially offset by the write-off of $583 million of receivables associated with the commercial risk corridor premium stabilization program, the loss of premiums associated with a large group Medicare account that moved to a private exchange on January 1, 2016, and a decline in premiums revenue associated with fewer individual commercial medical members as discussed in our segment results of operations discussion that follows. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

Consolidated services revenue decreased $437 million, or 31.1%, from 2015 to $1.0 billion for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Investment Income

Investment income totaled $389 million for 2016, a decrease of $85 million, or 17.9%, from 2015, primarily due to lower realized capital gains in 2016 and lower interest rates partially offset by a higher average invested balance.

Benefits Expense

Consolidated benefits expense was $45.0 billion for 2016, an increase of $738 million, or 1.7%, from 2015 primarily due to $505 million in incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies partially offset by the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the long-term care reserve strengthening and impact of the premium deficiency reserve, the increase is primarily due to an increase in the Retail segment mainly driven by higher average individual Medicare Advantage membership. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016 and $236 million in 2015. The increase in prior-period medical claims reserve development year over-year primarily was due to favorable year-over-year comparisons for our Medicare Advantage and individual commercial medical businesses.

The consolidated benefit ratio for 2016 was 84.9%, an increase of 40 basis points from 2015 primarily due to the incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies, the impact on the benefit ratio of lower consolidated premiums associated with the write-off of receivables for the commercial risk corridor premium stabilization program, and the impact of the premium deficiency reserve

recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the impact of the write-off of the commercial risk corridor receivables and the premium deficiency reserve, these items were partially offset by year-over-year improvement in both the Retail and Group segment benefit ratios as discussed in the segment results of operations discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 110 basis points in 2016 versus approximately 50 basis points in 2015.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs decreased $41 million, or 0.6%, from 2015 to $7.3 billion in 2016 primarily due to the completion of the sale of Concentra on June 1, 2015

The consolidated operating cost ratio for 2016 was 13.5%, decreasing 10 basis points from 2015 primarily due to the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio than our Group and Retail segments. This was partially offset by the unfavorable year-over-year comparison associated with the temporary suspension of certain discretionary administrative costs in the latter half of 2015, along with the impact of the commercial risk corridor receivables write-off in the fourth quarter of 2016. In addition, transaction and integration planning costs associated with the Merger increased the operating cost ratio by 20 basis points in 2016. There was minimal impact for transaction costs to the operating cost ratio in 2015.

Depreciation and Amortization

Depreciation and amortization for 2016 of $354 million was relatively unchanged from 2015.

Interest Expense

Interest expense was $189 million for 2016 compared to $186 million for 2015, an increase of $3 million, or 1.6%.

Income Taxes

Our effective tax rate during 2016 was 60.5% compared to the effective tax rate of 47.5% in 2015 primarily reflecting lower pretax income year-over-year, the beneficial effect of the sale of Concentra on June 1, 2015 and the impact of non-deductible transaction costs associated with the Merger. Non-deductible transaction and integration planning costs associated with the Merger increased our effective tax rate by approximately 3.4 percentage points in 2016 versus approximately 0.4 percentage points in 2015. Conversely, the tax effect of the sale of Concentra reduced our effective tax rate by approximately 4.5 percentage points in 2015. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate. Our effective tax rate for 2017 is expected to be approximately 36% to 37%. The decline in the effective tax rate primarily is due to the suspension of the annual health insurance industry fee in 2017.

The effective tax rate for 2016 also reflects tax benefits associated with adopting new guidance related to the accounting for employee share-based payments effective January 1, 2016 as described in Note 2 to the condensed consolidated financial statements included in this report, which decreased our effective tax rate by approximately 1.2 percentage points in 2016.

Retail Segment

			Change	
	2016	2015	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,837,600	2,753,400	84,200	3.1 %
Group Medicare Advantage	355,400	484,100	(128,700)	(26.6)%
Medicare stand-alone PDP	4,951,400	4,557,900	393,500	8.6 %
Total Retail Medicare	8,144,400	7,795,400	349,000	4.5 %
Individual commercial	654,800	899,100	(244,300)	(27.2)%
State-based Medicaid	388,100	373,700	14,400	3.9 %
Medicare Supplement	218,800	158,600	60,200	38.0 %
Total Retail medical members	9,406,100	9,226,800	179,300	1.9 %
Individual specialty membership (a)	1,088,100	1,153,100	(65,000)	(5.6)%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

			Change	
	2016	2015	Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 31,863	$ 29,526	$ 2,337	7.9 %
Group Medicare Advantage	4,283	5,588	(1,305)	(23.4)%
Medicare stand-alone PDP	4,009	3,846	163	4.2 %
Total Retail Medicare	40,155	38,960	1,195	3.1 %
Individual commercial	3,064	3,939	(875)	(22.2)%
State-based Medicaid	2,640	2,341	299	12.8 %
Medicare Supplement	428	304	124	40.8 %
Individual specialty	259	261	(2)	(0.8)%
Total premiums	46,546	45,805	741	1.6 %
Services	8	9	(1)	(11.1)%
Total premiums and services revenue	$ 46,554	$ 45,814	$ 740	1.6 %
Income before income taxes	$ 937	$ 930	$ 7	0.8 %
Benefit ratio	86.2%	86.7%		(0.5)%
Operating cost ratio	11.5%	11.2%		0.3 %

Pretax Results

- Retail segment pretax income was $937 million in 2016, an increase of $7 million, or 0.8%, compared to 2015 primarily driven by the year-over-year improvement in our individual Medicare Advantage and state-based Medicaid businesses along with the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 associated with certain individual commercial medical policies for the 2016 coverage year. These items were substantially offset by the write-off of commercial risk corridor receivables as discussed below.

Enrollment

- Individual Medicare Advantage membership increased 84,200 members, or 3.1%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, particularly for our HMO offerings, for the 2016 plan year.
- Group Medicare Advantage membership decreased 128,700 members, or 26.6%, from December 31, 2015 to December 31, 2016 reflecting the loss of a large account that moved to a private exchange offering on January 1, 2016.
- Medicare stand-alone PDP membership increased 393,500 members, or 8.6%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2016 plan year.
- Individual commercial medical membership decreased 244,300 members, or 27.2%, from December 31, 2015 to December 31, 2016 primarily reflecting the loss of on-exchange members due to product competitiveness, the loss of membership associated with the discontinuance of certain Health Care Reform Law compliant plans in 2016, the loss of membership associated with non-payment of premiums or termination by CMS due to lack of eligibility documentation, and the loss of members subscribing to plans that are not compliant with the Health Care Reform Law.
- State-based Medicaid membership increased 14,400 members, or 3.9%, from December 31, 2015 to December 31, 2016 primarily driven by the addition of members under our Florida Medicaid contract.
- Individual specialty membership decreased 65,000 members, or 5.6%, from December 31, 2015 to December 31, 2016 primarily due to the loss of individual commercial medical members that also had specialty coverage.

Premiums revenue

- Retail segment premiums increased $741 million, or 1.6%, from 2015 to 2016 primarily due to higher average membership for our individual Medicare Advantage and state-based Medicaid businesses and per member premium increases for certain lines of business. Average individual Medicare Advantage membership increased 3.9% in 2016. These items were partially offset by the write-off of approximately $583 million of receivables associated with the commercial risk corridor premium stabilization program, and declines in group Medicare Advantage (including the loss of a large group Medicare Advantage account) and individual commercial medical membership.

Benefits expense

- The Retail segment benefit ratio of 86.2% for 2016 decreased 50 basis points from 2015 primarily due to lower year-over-year Medicare Advantage utilization, favorable comparisons of prior-year medical claims reserve development, and the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. These items were partially offset by the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program which increased the Retail segment benefit ratio by approximately 100 basis points in 2016. As previously disclosed, in the fourth quarter of 2015 we recorded a premium deficiency reserve associated with our 2016 individual commercial offerings compliant with the Health Care Reform Law, increasing our 2015 benefit ratio by 40 basis points. During 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense primarily as a result of unfavorable current and projected claims experience.
- The Retail segment's benefits expense for 2016 included the beneficial effect of $535 million in favorable prior-year medical claims reserve development versus $228 million in 2015. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 110 basis points in

2016 versus approximately 50 basis points in 2015. The year-over-year increase in prior-period medical claims reserve development primarily was due to favorable year-over-year comparisons for our Medicare Advantage and individual commercial medical business.

Operating costs

- The Retail segment operating cost ratio of 11.5% for 2016 increased 30 basis points from 2015 primarily due to the impact on premiums of the write-off of receivables associated with the commercial risk corridor premium stabilization program, the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs, and the loss of a large group Medicare Advantage account which carried a lower operating cost ratio than that for our individual Medicare Advantage business. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016 as compared to 160 basis points in 2015.

Group Segment

			Change	
	2016	2015	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,136,000	1,178,300	(42,300)	(3.6)%
ASO	573,200	710,700	(137,500)	(19.3)%
Military services	3,084,100	3,074,400	9,700	0.3 %
Total group medical members	4,793,300	4,963,400	(170,100)	(3.4)%
Group specialty membership (a)	5,873,100	6,068,700	(195,600)	(3.2)%

(a) Specialty products include dental, vision, and other voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

			Change	
	2016	2015	Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,405	$ 5,493	$ (88)	(1.6)%
Group specialty	1,020	1,055	(35)	(3.3)%
Military services	12	21	(9)	(42.9)%
Total premiums	6,437	6,569	(132)	(2.0)%
Services	694	698	(4)	(0.6)%
Total premiums and services revenue	$ 7,131	$ 7,267	$ (136)	(1.9)%
Income before income taxes	$ 257	$ 258	$ (1)	(0.4)%
Benefit ratio	79.6%	80.2%		(0.6)%
Operating cost ratio	24.6%	24.0%		0.6 %

Pretax Results

- Group segment pretax income was relatively unchanged, decreasing $1 million, or 0.4%, to $257 million in 2016 as an increase in the operating cost ratio was substantially offset by improvement in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 42,300 members, or 3.6% from December 31, 2015 reflecting lower membership in both large and small group accounts.
- Group ASO commercial medical membership decreased 137,500 members, or 19.3%, from December 31, 2015 to December 31, 2016 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.
- Group specialty membership decreased 195,600 members, or 3.2%, from December 31, 2015 to December 31, 2016 primarily due to the loss of several large stand-alone dental and vision accounts as well as the loss of certain fully-insured group medical accounts that also had specialty coverage.

Premiums revenue

- Group segment premiums decreased $132 million, or 2.0%, from 2015 to 2016 primarily due to a decline in fully-insured commercial medical membership as described above, partially offset by an increase in fully-insured commercial medical per member premiums.

Services revenue

- Group segment services revenue decreased $4 million, or 0.6%, from 2015 to 2016 primarily due to a decline in group ASO commercial medical membership.

Benefits expense

- The Group segment benefit ratio decreased 60 basis points from 80.2% in 2015 to 79.6% in 2016 primarily reflecting the beneficial effect of higher prior-year medical claims reserve development in 2016 and lower utilization.
- The Group segment's benefits expense included the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2016 versus $7 million in 2015. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 70 basis points in 2016 versus approximately 10 basis points in 2015.

Operating costs

- The Group segment operating cost ratio of 24.6% for 2016 increased 60 basis points from 24.0% for 2015 primarily due to the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016 as compared to 140 basis points in 2015.

Healthcare Services Segment

	2016	2015	Change Dollars	Change Percentage
	(in millions)			
Revenues:				
Services:				
Provider services	$ 78	$ 515	$ (437)	(84.9)%
Home based services	148	140	8	5.7 %
Pharmacy solutions	31	30	1	3.3 %
Total services revenues	257	685	(428)	(62.5)%
Intersegment revenues:				
Pharmacy solutions	21,952	20,551	1,401	6.8 %
Provider services	1,677	1,291	386	29.9 %
Home based services	1,026	875	151	17.3 %
Clinical programs	180	203	(23)	(11.3)%
Total intersegment revenues	24,835	22,920	1,915	8.4 %
Total services and intersegment revenues	$ 25,092	$ 23,605	$ 1,487	6.3 %
Income before income taxes	$ 1,067	$ 981	$ 86	8.8 %
Operating cost ratio	95.4%	95.2%		0.2 %

Pretax results

- Healthcare Services segment pretax income of $1,067 million for 2016 increased $86 million, or 8.8%, from 2015 primarily due to incremental earnings associated with revenue growth from our pharmacy solutions business as it increased mail-order penetration and served our growing individual Medicare membership. The increase was partially offset by ongoing pressures in our provider services business reflecting significantly lower Medicare rates year-over-year associated with CMS' risk coding recalibration for 2016 in geographies where our provider assets are primarily located.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 426 million in 2016, up 7% versus scripts of approximately 398 million in 2015. The increase primarily reflects growth associated with higher average medical membership for 2016 than in 2015.

Services revenue

- Services revenue decreased $428 million, or 62.5%, from 2015 to $257 million for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $1.9 billion, or 8.4%, from 2015 to $24.8 billion for 2016 primarily due to increased mail order penetration and growth in our individual Medicare Advantage and Medicare stand-alone PDP membership which resulted in increased engagement of members in clinical programs and higher utilization of services across the segment.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.4% for 2016 increased slightly from 2015 primarily due to a higher operating cost ratio for our provider services business reflecting significantly lower Medicare rates year-over-year as discussed above, partially offset by operating cost efficiencies associated with our pharmacy operations.

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Comparison of Results of Operations for 2015 and 2014

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2015 and 2014:

Consolidated

	2015	2014	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 45,805	$ 39,452	$ 6,353	16.1 %
Group	6,569	6,456	113	1.8 %
Other Businesses	35	51	(16)	(31.4)%
Total premiums	52,409	45,959	6,450	14.0 %
Services:				
Retail	9	39	(30)	(76.9)%
Group	698	763	(65)	(8.5)%
Healthcare Services	685	1,353	(668)	(49.4)%
Other Businesses	14	9	5	55.6 %
Total services	1,406	2,164	(758)	(35.0)%
Investment income	474	377	97	25.7 %
Total revenues	54,289	48,500	5,789	11.9 %
Operating expenses:				
Benefits	44,269	38,166	6,103	16.0 %
Operating costs	7,318	7,639	(321)	(4.2)%
Depreciation and amortization	355	333	22	6.6 %
Total operating expenses	51,942	46,138	5,804	12.6 %
Income from operations	2,347	2,362	(15)	(0.6)%
Gain on sale of business	270	—	270	100.0 %
Interest expense	186	192	(6)	(3.1)%
Income before income taxes	2,431	2,170	261	12.0 %
Provision for income taxes	1,155	1,023	132	12.9 %
Net income	$ 1,276	$ 1,147	$ 129	11.2 %
Diluted earnings per common share	$ 8.44	$ 7.36	$ 1.08	14.7 %
Benefit ratio (a)	84.5%	83.0%		1.5 %
Operating cost ratio (b)	13.6%	15.9%		(2.3)%
Effective tax rate	47.5%	47.2%		0.3 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income was $1.3 billion, or $8.44 per diluted common share, in 2015 compared to $1.1 billion, or $7.36 per diluted common share, in 2014. The completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain of $1.57 per diluted common share in 2015. Excluding the impact of the sale of Concentra, the decrease primarily was

due to a decline in Retail segment pretax results, including expense of $0.74 per diluted common share for a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and an increase in the effective tax rate as discussed below. These items were partially offset by year-over-year improvement in the Group and Healthcare Services segment pretax results and higher investment income. In addition, 2015 includes expenses of $0.14 per diluted common share for transaction costs associated with the Merger, certain of which were not deductible for tax purposes. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014. Year-over-year comparisons of diluted earnings per common share are also favorably impacted by a lower number of shares used to compute diluted earnings per common share in 2015 reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $6.5 billion, or 14.0%, from 2014 to $52.4 billion for 2015 primarily reflecting higher premiums in both the Retail and Group segments. These higher premiums were primarily driven by average membership growth in the Retail segment and an increase in fully-insured group commercial medical per member premiums in the Group segment.

Services Revenue

Consolidated services revenue decreased $758 million, or 35.0%, from 2014 to $1.4 billion for 2015 primarily due to the completion of the sale of Concentra on June 1, 2015 as well as the loss of certain large group ASO accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

Investment Income

Investment income totaled $474 million for 2015, an increase of $97 million from 2014, primarily due to higher realized capital gains in 2015 as a result of the repositioning of our portfolio given recent market volatility and anticipated changes to interest rates, with higher average invested balances being substantially offset by lower interest rates.

Benefits Expense

Consolidated benefits expense was $44.3 billion for 2015, an increase of $6.1 billion, or 16.0%, from 2014 primarily due to an increase in the Retail segment mainly driven by higher average Medicare Advantage membership and individual commercial medical on-exchange and off-exchange membership in plans compliant with the Health Care Reform Law. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $236 million in 2015 and $518 million in 2014. The decline in prior-period medical claims reserve development year over-year primarily was due to Medicare Advantage and individual commercial medical claims development in the Retail segment as discussed further in the segment results of operations discussion that follows.

The consolidated benefit ratio for 2015 was 84.5%, an increase of 150 basis points from 2014 primarily due to increases in the Retail segment, including the impact of recognizing a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and Group segment ratios as discussed in the segment results of operations discussion that follows. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the consolidated benefit ratio by approximately 30 basis points in 2015. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 50 basis points in 2015 versus approximately 110 basis points in 2014.

Operating Costs

Consolidated operating costs decreased $321 million, or 4.2%, in 2015 compared to 2014 primarily due to cost management initiatives across all lines of business as well as the completion of the sale of Concentra on June 1, 2015, partially offset by increases in costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee.

The consolidated operating cost ratio for 2015 was 13.6%, decreasing 230 basis points from 2014 primarily due to decreases in the operating cost ratios in the Group and Retail segments reflecting cost management initiatives, as well as the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio.

Depreciation and Amortization

Depreciation and amortization for 2015 totaled $355 million, increasing $22 million, or 6.6% from 2014, reflecting higher depreciation expense from capital expenditures.

Interest Expense

Interest expense was $186 million for 2015 compared to $192 million for 2014, a decrease of $6 million, or 3.1%, primarily reflecting a higher average long-term debt balance due to the issuance of senior notes in September 2014, partially offset by the recognition of a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of our $500 million 6.45% senior unsecured notes due June 1, 2016.

Income Taxes

Our effective tax rate during 2015 was 47.5% compared to the effective tax rate of 47.2% in 2014. The increase in the effective tax rate primarily was due to an increase in the non-deductible health insurance industry fee from 2014, substantially offset by the favorable tax effect of the gain on the sale of Concentra. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2015	2014	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,753,400	2,427,900	325,500	13.4 %
Group Medicare Advantage	484,100	489,700	(5,600)	(1.1)%
Medicare stand-alone PDP	4,557,900	3,994,000	563,900	14.1 %
Total Retail Medicare	7,795,400	6,911,600	883,800	12.8 %
Individual commercial	899,100	1,016,200	(117,100)	(11.5)%
State-based Medicaid	373,700	316,800	56,900	18.0 %
Medicare Supplement	158,600	131,900	26,700	20.2 %
Total Retail medical members	9,226,800	8,376,500	850,300	10.2 %
Individual specialty membership (a)	1,153,100	1,165,800	(12,700)	(1.1)%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2015	2014	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 29,526	$ 25,782	$ 3,744	14.5 %
Group Medicare Advantage	5,588	5,490	98	1.8 %
Medicare stand-alone PDP	3,846	3,404	442	13.0 %
Total Retail Medicare	38,960	34,676	4,284	12.4 %
Individual commercial	3,939	3,020	919	30.4 %
State-based Medicaid	2,341	1,255	1,086	86.5 %
Medicare Supplement	304	245	59	24.1 %
Individual specialty	261	256	5	2.0 %
Total premiums	45,805	39,452	6,353	16.1 %
Services	9	39	(30)	(76.9)%
Total premiums and services revenue	$ 45,814	$ 39,491	$ 6,323	16.0 %
Income before income taxes	$ 930	$ 1,339	$ (409)	(30.5)%
Benefit ratio	86.7%	84.9%		1.8 %
Operating cost ratio	11.2%	11.6%		(0.4)%

Pretax Results

- Retail segment pretax income was $930 million in 2015, a decrease of $409 million, or 30.5%, compared to 2014 primarily driven by an increase in the benefit ratio for 2015, including the impact of recognizing a premium deficiency reserve of approximately $176 million for certain of our individual commercial medical products for the 2016 coverage year, partially offset by a decline in the operating cost ratio, Medicare Advantage membership growth, and higher investment income year-over-year.

Enrollment

- Individual Medicare Advantage membership increased 325,500 members, or 13.4%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, particularly for our HMO offerings, for the 2015 plan year.
- Group Medicare Advantage membership decreased 5,600 members, or 1.1%, from December 31, 2014 to December 31, 2015.
- Medicare stand-alone PDP membership increased 563,900 members, or 14.1%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2015 plan year.
- Individual commercial medical membership decreased 117,100 members, or 11.5%, from December 31, 2014 to December 31, 2015 primarily reflecting the loss of approximately 150,000 members due to termination by CMS for lack of proper eligibility documentation from the member as well as the loss of members who had subscribed to plans that were not compliant with the Health Care Reform Law. These declines were partially offset by an increase in membership in plans that are compliant with the Health Care Reform Law, primarily off-exchange
- State-based Medicaid membership increased 56,900 members, or 18.0%, from December 31, 2014 to December 31, 2015 primarily driven by the addition of members under our Florida Medicaid contract.

- Individual specialty membership decreased 12,700 members, or 1.1%, from December 31, 2014 to December 31, 2015 primarily driven by a membership decline in supplemental health and financial protection product and vision offerings.

Premiums revenue

- Retail segment premiums increased $6.4 billion, or 16.1%, from 2014 to 2015 primarily due to membership growth across our Medicare Advantage, state-based Medicaid, and Medicare stand-alone PDP lines of business, as well as a heavier percentage of individual commercial medical business in higher premium plans compliant with the Health Care Reform Law. Average Medicare Advantage membership increased 11.8% in 2015.

Benefits expense

- The Retail segment benefit ratio of 86.7% for 2015 increased 180 basis points from 2014 primarily due to higher than expected medical costs as compared to the assumptions used in our pricing, the recognition of a premium deficiency reserve in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year, and unfavorable year-over-year comparisons of prior-period medical claims reserve development as discussed below. In addition, the increase reflects higher benefit ratios associated with a greater number of members from state-based contracts and the impact of the change in estimate for the 2014 net 3Rs receivables in 2015. These items were partially offset by the impact of the increase in the health insurance industry fee included in the pricing of our products. In addition, the 2015 period was favorably impacted by the release of reserves for future policy benefits as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

- We experienced higher than expected medical costs as compared to the assumptions used in our pricing for 2015 primarily due to lower-than-expected 2015 Medicare Advantage financial claim recovery levels and lower-than-anticipated reductions in inpatient admissions. In addition, medical claims associated with certain individual commercial medical products, in particular products compliant with the Health Care Reform Law, exceeded the assumptions used when we set pricing for 2015. We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the Retail segment benefit ratio by approximately 40 basis points in 2015.

- The Retail segment's benefits expense for 2015 included the beneficial effect of $228 million in favorable prior-year medical claims reserve development versus $488 million in 2014. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 50 basis points in 2015 versus approximately 120 basis points in 2014. The year-over-year decline in prior-period medical claims reserve development primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products.

Operating costs

- The Retail segment operating cost ratio of 11.2% for 2015 decreased 40 basis points from 2014 primarily reflecting administrative cost efficiencies associated with medical membership growth in the segment and other discretionary cost reductions, partially offset by the increase in the non-deductible health insurance

industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2015 as compared to 120 basis points in 2014.

Group Segment

			Change	
	2015	2014	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,178,300	1,235,500	(57,200)	(4.6)%
ASO	710,700	1,104,300	(393,600)	(35.6)%
Military services	3,074,400	3,090,400	(16,000)	(0.5)%
Total group medical members	4,963,400	5,430,200	(466,800)	(8.6)%
Group specialty membership (a)	6,068,700	6,502,700	(434,000)	(6.7)%

(a) Specialty products include dental, vision, and voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

			Change	
	2015	2014	Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,493	$ 5,339	$ 154	2.9 %
Group specialty	1,055	1,098	(43)	(3.9)%
Military services	21	19	2	10.5 %
Total premiums	6,569	6,456	113	1.8 %
Services	698	763	(65)	(8.5)%
Total premiums and services revenue	$ 7,267	$ 7,219	$ 48	0.7 %
Income before income taxes	$ 258	$ 151	$ 107	70.9 %
Benefit ratio	80.2%	79.5%		0.7 %
Operating cost ratio	24.0%	26.5%		(2.5)%

Pretax Results

- Group segment pretax income increased $107 million, or 70.9%, to $258 million in 2015 primarily reflecting improvement in the operating cost ratio partially offset by an increase in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 57,200 members, or 4.6% from December 31, 2014 reflecting lower membership in both large and small group accounts.
- Group ASO commercial medical membership decreased 393,600 members, or 35.6%, from December 31, 2014 to December 31, 2015 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.
- Group specialty membership decreased 434,000 members, or 6.7%, from December 31, 2014 to December 31, 2015 primarily due to the loss of certain fully-insured group medical accounts that also had specialty coverage.

Premiums revenue

- Group segment premiums increased $113.0 million, or 1.8%, from 2014 to 2015 primarily due to an increase in fully-insured commercial medical per member premiums partially offset by a net decline in fully-insured commercial medical membership.

Benefits expense

- The Group segment benefit ratio increased 70 basis points from 79.5% in 2014 to 80.2% in 2015 primarily reflecting the impact of higher specialty drug costs, net of rebates, as well as higher outpatient costs and lower prior-period medical claims reserve development, partially offset by an increase in the non-deductible health insurance industry fee included in the pricing of our products.

- The Group segment's benefits expense included the beneficial effect of $7 million in favorable prior-year medical claims reserve development versus $29 million in 2014. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 10 basis points in 2015 versus approximately 40 basis points in 2014. The year-over-year decline in favorable prior-period medical claims reserve development primarily was due to a relatively small number of higher severity claims in the 2015 period associated with prior periods.

Operating costs

- The Group segment operating cost ratio of 24.0% for 2015 decreased 250 basis points from 26.5% for 2014, reflecting a decline in our group ASO commercial medical membership which carries a higher operating cost ratio than our fully-insured commercial medical membership, as well as operating cost efficiencies associated with our fully-insured business. Operating cost efficiencies were the result of both sustainable cost reduction initiatives and discretionary reductions. These declines were partially offset by the impact of an increase in the non-deductible health insurance industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 140 basis points in 2015 as compared to 100 basis points in 2014.

Healthcare Services Segment

			Change	
	2015	2014	Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Provider services	$ 515	$ 1,147	$ (632)	(55.1)%
Home based services	140	107	33	30.8 %
Pharmacy solutions	30	99	(69)	(69.7)%
Total services revenues	685	1,353	(668)	(49.4)%
Intersegment revenues:				
Pharmacy solutions	20,551	16,905	3,646	21.6 %
Provider services	1,291	1,149	142	12.4 %
Home based services	875	585	290	49.6 %
Clinical programs	203	208	(5)	(2.4)%
Total intersegment revenues	22,920	18,847	4,073	21.6 %
Total services and intersegment revenues	$ 23,605	$ 20,200	$ 3,405	16.9 %
Income before income taxes	$ 981	$ 738	$ 243	32.9 %
Operating cost ratio	95.2%	95.6%		(0.4)%

Pretax results

- Healthcare Services segment pretax income of $981 million for 2015 increased $243 million, or 32.9%, from 2014 primarily due to higher earnings from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 398 million in 2015, up 21% versus scripts of approximately 329 million in 2014. The increase primarily reflects growth associated with higher average medical membership for 2015 than in 2014.

Services revenue

- Services revenue for 2015 decreased $668 million, or 49.4% from 2014, to $685 million for 2015, primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $4.1 billion, or 21.6%, from 2014 to $22.9 billion for 2015 primarily due to growth in our Medicare membership which resulted in higher utilization of our Healthcare Services segment businesses.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.2% for 2015 decreased 40 basis points from 95.6% for 2014 primarily due to lower operating costs in our pharmacy business together with discretionary cost reductions across the segment, partially offset by the increasing percentage of pharmacy business associated with lower margin specialty drugs. Improving operating efficiency in the pharmacy business was primarily driven by lower cost of goods associated with increased purchasing scale and lower cost-to-fill primarily due to improvements in technology.

Liquidity

Historically, our primary sources of cash have included receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities, borrowings, and proceeds from sales of businesses. Our primary uses of cash historically have included disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including premiums receivable, benefits payable, and other receivables and payables. Our cash flows are impacted by the timing of payments to and receipts from CMS associated with Medicare Part D subsidies for which we do not assume risk. The use of operating cash flows may be limited by regulatory requirements of state departments of insurance (or comparable state regulators) which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law impact the timing of our operating cash flows, as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. During 2016, net collections under the 3Rs associated with prior coverage years were $383 million. We expect to collect the remaining $54 million of reinsurance recoverables related to prior coverage years in 2017. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all

of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2016, we collected approximately $36 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. The remaining net receivable balance associated with the 3Rs was approximately $456 million at December 31, 2016, including the $54 million related to the 2015 coverage year, as compared to $982 million at December 31, 2015. Any amounts receivable or payable associated with these risk limiting programs may have an impact on subsidiary liquidity, with any temporary shortfalls funded by the parent company.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2016 Form 10-K.

Cash and cash equivalents increased to $3.9 billion at December 31, 2016 from $2.6 billion at December 31, 2015. The change in cash and cash equivalents for the years ended December 31, 2016, 2015 and 2014 is summarized as follows:

	2016	2015	2014
		(in millions)	
Net cash provided by operating activities	$ 1,936	$ 868	$ 1,618
Net cash (used in) provided by investing activities	(1,362)	320	(63)
Net cash provided by (used in) financing activities	732	(552)	(758)
Increase in cash and cash equivalents	$ 1,306	$ 636	$ 797

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The increase in operating cash flows in 2016 primarily was due to significantly favorable working capital items and higher earnings exclusive of the commercial risk corridor receivables write-off and the long-term care reserve strengthening in 2016, as well as the gain on sale of Concentra and the recognition of the premium deficiency reserve in 2015 discussed previously. The working capital changes year-over-year primarily reflect lower income tax payments, changes in the net receivable balance associated with the premium stabilization programs established under health care reform, or the 3R's, and the timing of payroll cycles resulting in one less payroll cycle in 2016, partially offset by the timing of payments for benefits expense. The lower operating cash flows in 2015 primarily reflect the effect of significant growth in individual commercial medical and group Medicare Advantage membership in 2014 and changes in the timing of working capital items related to the growth in our pharmacy business.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. We illustrate these changes with the following summaries of benefits payable and receivables.

The detail of benefits payable was as follows at December 31, 2016, 2015 and 2014:

				Change		
	2016	2015	2014	2016	2015	2014
			(in millions)			
IBNR (1)	$ 3,422	$ 3,730	$ 3,254	$ (308)	$ 476	$ 668
Reported claims in process (2)	654	600	475	54	125	94
Premium deficiency reserve (3)	—	176	—	(176)	176	—
Other benefits payable (4)	487	470	746	17	(276)	(180)
Total benefits payable	$ 4,563	$ 4,976	$ 4,475	$ (413)	$ 501	$ 582

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).
(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.
(3) Premium deficiency reserve recognized for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.
(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The decrease in benefits payable in 2016 largely was due to a decrease in IBNR, discussed further below, as well as the application of 2016 results to the premium deficiency reserve liability recognized in 2015 associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year. There was no premium deficiency reserve liability at December 31, 2016. The increases in benefits payable in 2015 and 2014 largely were due to increases in IBNR as well as an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuates due to month-end cutoff. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements in both 2015 and 2014, including the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. In addition, benefits payable in 2015 reflects the recognition of the premium deficiency reserve discussed previously.

IBNR decreased during 2016 primarily due to declines in group Medicare Advantage, individual commercial medical, and fully-insured commercial group medical membership in 2016. IBNR increased during 2015 primarily as a result of individual Medicare Advantage membership growth while during 2014 IBNR also increased as a result of individual Medicare Advantage membership growth as well as significant growth in individual commercial medical and group Medicare Advantage membership. As discussed previously, our cash flows are impacted by changes in enrollment. In 2014 (the first year plans compliant with the Health Care Reform Law were effective), membership in new fully-insured individual commercial medical plans compliant with the Health Care Reform Law grew as compared with much lower growth in membership in these plans in 2015 and a decline in membership in these plans in 2016. Similarly, growth in group Medicare Advantage membership in 2014 favorably impacted the 2014 cash flows while a decline in group Medicare Advantage membership in 2015 and more significantly in 2016, negatively impacted the 2015 and 2016 cash flows.

The detail of total net receivables was as follows at December 31, 2016, 2015 and 2014:

				Change		
	2016	2015	2014	2016	2015	2014
			(in millions)			
Medicare	$ 787	$ 765	$ 664	$ 22	$ 101	$ 88
Commercial and other	579	420	381	159	39	162
Military services	32	77	106	(45)	(29)	19
Allowance for doubtful accounts	(118)	(101)	(98)	(17)	(3)	(27)
Total net receivables	$ 1,280	$ 1,161	$ 1,053	119	108	242
Reconciliation to cash flow statement:						
Provision for doubtful accounts				39	61	32
Change in receivables acquired, held-for-sale, or disposed from sale of business				—	11	(10)
Change in receivables per cash flow statement resulting in cash from operations				$ 158	$ 180	$ 264

As disclosed previously, on June 1, 2015, we completed the sale of our wholly owned subsidiary Concentra. Net receivables associated with Concentra were classified as held-for-sale at December 31, 2014 excluded from the table above for comparative purposes.

Medicare receivables are impacted by changes in revenue associated with individual and group Medicare membership changes as well as the timing of accruals and related collections associated with the CMS risk-adjustment model.

The increases in commercial and other receivables in 2016 as compared to 2015 primarily reflects an increase in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. Similarly, excluding the effect of classifying Concentra receivables as held-for-sale at December 31, 2014, the increase in commercial and other receivables in 2014 primarily was due to the commercial risk adjustment provisions of the Health Care Reform Law which became effective in 2014.

Military services receivables at December 31, 2016, 2015, and 2014 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our current TRICARE South Region contract.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impact our operating cash flows as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. During 2016, net collections under the 3Rs associated with prior coverage years were $383 million as compared to net collections of $417 million in 2015. There were no amounts collected in 2014, the first year of the programs. The net receivable balance associated with the 3Rs was approximately $456 million at December 31, 2016, including certain amounts recorded in receivables as noted above. In 2016, we paid the federal government $916 million for the annual health insurance industry fee compared to our payments of $867 million in 2015 and $562 million in 2014.

In addition to the timing of payments of benefits expense, receipts for premiums and services revenues, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other items impacting operating cash flows include income tax payments and the timing of payroll cycles resulting in one less payroll cycle in 2016 than in 2015.

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $527 million in 2016, $523 million in 2015, and $528 million in 2014.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $828 million in 2016. Proceeds from sales and maturities of investment securities exceeded purchases by $103 million in 2015 and $411 million in 2014. These net proceeds were used to fund normal working capital needs due to an increase in receivables associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below.

In 2015, we purchased a $284 million note receivable directly from a third-party bank syndicate related to the financing of MCCI Holdings, LLC's business as described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The purchase of this note is included with purchases of investment securities in our consolidated statement of cash flows.

On June 1, 2015, we completed the sale of Concentra for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs.

Cash consideration paid for acquisitions, net of cash acquired, was $7 million in 2016, $38 million in 2015, and $18 million in 2014. Acquisitions in each year included health and wellness related acquisitions.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were $1.1 billion higher than claims payments during 2016. Conversely, claims payments were $361 million higher than receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk during 2015 and $945 million higher during 2014. In 2014 and 2015, we experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher subsidy receivable balances in those years that were settled in 2015 and 2016, respectively, under the terms of our contracts with CMS. Our net receivable for CMS subsidies and brand name prescription drug discounts was $0.9 billion at December 31, 2016 compared to $2.0 billion at December 31, 2015. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our administrative services only TRICARE South Region contract, health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $25 million in 2016 and by $4 million in 2015. Reimbursements from the federal government equaled health care cost payments for which we do not assume risk in 2014.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $28 million in 2016 and less than reimbursements by $69 million in 2015 and by $26 million in 2014. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 1.85 million shares for $329 million in 2015 and 5.7 million shares for $730 million in 2014(excludes another $100 million held back pending final settlement of an accelerated stock repurchase plan in March 2015) under share repurchase plans authorized by the Board of Directors. We did not repurchase shares in 2016 due to restrictions under the Merger Agreement. We also acquired common shares in connection with employee stock plans for an aggregate cost of $104 million in 2016, $56 million in 2015, and $42 million in 2014.

As discussed further below, we paid dividends to stockholders of $177 million in 2016 and $172 million in each of 2015 and 2014.

We entered into a commercial paper program in October 2014. Net repayments of commercial paper were $2 million in 2016 and the maximum principal amount outstanding at any one time during 2016 was $475 million. Net proceeds from the issuance of commercial paper were $298 million in 2015 and the maximum principal amount outstanding at any one time during 2015 was $414 million. There were no net proceeds from the issuance of commercial paper in 2014 and the maximum principal amount outstanding at any one time during 2014 was $175 million.

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem our $500 million 6.45% senior unsecured notes.

The remainder of the cash used in or provided by financing activities in 2016, 2015, and 2014 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

For a detailed discussion of dividends to stockholders, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Stock Repurchases

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, and also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. Under this new authorization, we expect to complete a $1.5 billion accelerated share repurchase program in the first quarter of 2017. For a detailed discussion of stock repurchases, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Debt

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2016 was A- according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company

increased to $2.0 billion at December 31, 2016 from $1.6 billion at December 31, 2015. This increase primarily reflects operating cash derived from our non-insurance subsidiaries' profits partially offset by capital expenditures, payment of stockholder dividends, and common stock repurchases. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated subsidiaries paid dividends to the parent of $763 million in 2016, $493 million in 2015, and $927 million in 2014. Subsidiary dividends in 2015 reflect the impact of losses for our individual commercial medical business compliant with the Health Care Reform Law and the November 5, 2015 revised statutory accounting guidance requiring the exclusion of risk corridor receivables from related statutory surplus. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2017 is approximately $850 million, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Our parent company funded a subsidiary capital contribution of approximately $535 million in the first quarter of 2017 for reserve strengthening associated with our closed block of long-term care insurance policies discussed further in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

In 2016, we paid the federal government $916 million for the annual health insurance industry fee. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2016 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
	(in millions)				
Debt	$ 4,100	$ 300	$ 1,200	$ —	$ 2,600
Interest (1)	2,354	188	283	236	1,647
Operating leases (2)	697	185	283	134	95
Purchase obligations (3)	348	184	156	7	1
Future policy benefits payable and other long-term liabilities (4)	3,279	93	453	215	2,518
Total	$ 10,778	$ 950	$ 2,375	$ 592	$ 6,861

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2037. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

Off-Balance Sheet Arrangements

As of December 31, 2016, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Other

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do. Penn Treaty is a financially distressed unaffiliated long-term care insurance company. A final court ruling on Penn Treaty's insolvency would trigger a guarantee fund assessment that would result in expense for us, based on current information, estimated at approximately $30 million.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies primarily related to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2016	Percentage of Total	December 31, 2015	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,422	75.0%	$ 3,730	75.0%
Reported claims in process	654	14.3%	600	12.1%
Premium deficiency reserve	—	—%	176	3.5%
Other benefits payable	487	10.7%	470	9.4%
Total benefits payable	$ 4,563	100.0%	$ 4,976	100.0%

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. For further discussion of our reserving methodology, including our use of completion and claims per member per month trend factors to estimate IBNR, refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderate adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2016 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.60%	$(186)	(2.75)%	$(296)
0.50%	$(155)	(2.50)%	$(269)
0.40%	$(124)	(2.25)%	$(242)
0.30%	$(93)	(2.00)%	$(215)
0.20%	$(62)	(1.75)%	$(188)
0.10%	$(31)	(1.50)%	$(162)
—%	$—	(1.25)%	$(135)

(a) Reflects estimated potential changes in benefits payable at December 31, 2016 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2016 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail and Group segment tables including information about incurred and paid claims development as of December 31, 2016, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2016	2015	2014
	(in millions)		
Balances at January 1	$ 4,976	$ 4,475	$ 3,893
Less: Premium deficiency reserve	(176)	—	—
Less: Reinsurance recoverables	(85)	(78)	—
Balances at January 1, net	4,715	4,397	3,893
Incurred related to:			
Current year	45,318	44,397	38,641
Prior years	(582)	(236)	(518)
Total incurred	44,736	44,161	38,123
Paid related to:			
Current year	(40,852)	(39,802)	(34,357)
Prior years	(4,112)	(4,041)	(3,262)
Total paid	(44,964)	(43,843)	(37,619)
Premium deficiency reserve	—	176	—
Reinsurance recoverable	76	85	78
Balances at December 31	$ 4,563	$ 4,976	$ 4,475

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2016		2015		2014	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (316)	(2.9)%	$ (145)	(1.5)%	$ (266)	(3.7)%
Completion factors	(266)	0.9 %	(91)	0.4 %	(252)	1.2 %
Total	$ (582)		$ (236)		$ (518)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016, $236 million in 2015, and $518 million in 2014. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2016, 2015, and 2014.

	Favorable Medical Claims Reserve Development			Change	
	2016	2015	2014	2016	2015
	(in millions)				
Retail Segment	$ (535)	$ (228)	$ (488)	$ (307)	$ 260
Group Segment	(46)	(7)	(29)	(39)	22
Other Businesses	(1)	(1)	(1)	—	—
Total	$ (582)	$ (236)	$ (518)	$ (346)	$ 282

The favorable medical claims reserve development for 2016, 2015, and 2014 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2016 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Premium deficiency reserve for short-duration policies	$ (176)	$ 176	$ —
Military services	8	12	11
Future policy benefits	439	(80)	32
Total	$ 271	$ 108	$ 43

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Military services benefits expense for each year in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described below and in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Certain health policies sold to individuals prior to 2014 (the first year plans compliant with the Health Care Reform Law were effective) are accounted for as long-duration as more fully described below. The decrease in benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

Future policy benefits payable of $2.8 billion and $2.2 billion at December 31, 2016 and 2015, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present

value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $2.2 billion at December 31, 2016 and $1.5 billion at December 31, 2015 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 30,800 policies remain in force as of December 31, 2016. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was a $77 million additional liability at December 31, 2016 and no additional liability at December 31, 2015. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. A prolonged period during which interest rates remain at levels lower than those anticipated in our reserving would result in shortfalls in investment income on assets supporting our obligation under long term care policies because the long duration of the policy obligations exceeds the duration of the supporting investment assets. Further, we monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, future material adjustments to reserves could be required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets.

For our closed block of long-term care policies, actuarial assumptions used to estimate reserves are inherently uncertain due to the potential changes in trends in mortality, morbidity, persistency and interest rates as well as premium rate increases. As a result, our long term care reserves may be subject to material increases if these trends develop adversely to our expectations. The estimated increase in reserves and additional benefit expense from hypothetically modeling adverse variations in our actuarial assumptions, in the aggregate, could be up to $250 million, net of reinsurance. Although such hypothetical revisions are not currently appropriate, we believe they could occur based on past variances in experience and our expectation of the ranges of future experience that could reasonably occur, and any such revision could be material. Generally accepted accounting principles do not allow us to unlock our assumptions for favorable items.

In addition, future policy benefits payable includes amounts of $201 million at December 31, 2016, $205 million at December 31, 2015, and $210 million at December 31, 2014 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Our commercial contracts establish rates on a per employee basis for each month of coverage based on the type of coverage purchased (single to family coverage options). Our Medicare and Medicaid contracts also establish monthly rates per member. However, our Medicare contracts also have additional provisions as outlined in the following separate section.

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer's enrollment and individuals that ultimately may fail to pay, and for estimated rebates under the minimum benefit ratios required under the Health Care Reform Law. Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on available data and historical trends. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in the current period's revenue.

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Investment Securities

Investment securities totaled $9.8 billion, or 39% of total assets at December 31, 2016, and $9.1 billion, or 37% of total assets at December 31, 2015. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2016 and 2015. The fair value of debt securities were as follows at December 31, 2016 and 2015:

	December 31, 2016	Percentage of Total	December 31, 2015	Percentage of Total
			(dollars in millions)	
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 786	8.0%	$ 332	3.6%
Mortgage-backed securities	1,637	16.7%	1,891	20.8%
Tax-exempt municipal securities	3,305	33.7%	2,668	29.3%
Mortgage-backed securities:				
Residential	9	0.1%	13	0.1%
Commercial	304	3.1%	985	10.8%
Asset-backed securities	160	1.7%	263	2.9%
Corporate debt securities	3,597	36.7%	2,958	32.5%
Total debt securities	$ 9,798	100.0%	$ 9,110	100.0%

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2016. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $276 million at December 31, 2016 and $178 million at December 31, 2015. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.4 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.6 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $132 million and $173 million at December 31, 2016 and 2015, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was less than $1 million at December 31, 2016 and $1 million at December 31, 2015. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial services industry was 23% at December 31, 2016 and 25% at December 31, 2015.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2016:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2016						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 697	$ (15)	$ 3	$ —	$ 700	$ (15)
Mortgage-backed securities	1,528	(31)	3	—	1,531	(31)
Tax-exempt municipal securities	2,756	(67)	43	(1)	2,799	(68)
Mortgage-backed securities:						
Residential	—	—	4	—	4	—
Commercial	182	(3)	24	(1)	206	(4)
Asset-backed securities	51	—	63	—	114	—
Corporate debt securities	1,544	(71)	69	(7)	1,613	(78)
Total debt securities	$ 6,758	$ (187)	$ 209	$ (9)	$ 6,967	$ (196)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is other than temporary requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2016 primarily were composed of senior tranches having high

credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2016.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2016 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2016, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2016. There were no material other-than-temporary impairments in 2016, 2015, or 2014.

Goodwill and Long-lived Assets

At December 31, 2016, goodwill and other long-lived assets represented 20% of total assets and 47% of total stockholders' equity, compared to 20% and 48%, respectively, at December 31, 2015.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2015 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our provider services reporting unit in our Healthcare Services segment. The provider services reporting unit would decline to less than 10% margin after factoring in a 100 basis point increase in the discount rate.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $1.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2016 or December 31, 2015.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2016. Our net unrealized position decreased $120 million from a net unrealized gain position of $92 million at December 31, 2015 to a net unrealized loss position of $28 million at December 31, 2016. At December 31, 2016, we had gross unrealized losses of $196 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2016. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.4 years as of December 31, 2016 and 4.1 years as of December 31, 2015. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $590 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2016 and 2015. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points two times, and have changed by less than 100 basis points seven times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2016						
Investment income (a)	$ (49)	$ (44)	$ (36)	$ 53	$ 107	$ 162
Interest expense (b)	3	3	3	(2)	(5)	(9)
Pretax	$ (46)	$ (41)	$ (33)	$ 51	$ 102	$ 153
As of December 31, 2015						
Investment income (a)	$ (33)	$ (27)	$ (21)	$ 41	$ 82	$ 124
Interest expense (b)	3	3	3	(3)	(6)	(9)
Pretax	$ (30)	$ (24)	$ (18)	$ 38	$ 76	$ 115

(a) As of December 31, 2016 and 2015, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2016 or December 31, 2015. There was $300 million outstanding under our commercial paper program at December 31, 2016. As of December 31, 2016, our interest rate under our commercial paper program was less than 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2016	2015
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,877	$ 2,571
Investment securities	7,595	7,267
Receivables, less allowance for doubtful accounts of $118 in 2016 and $101 in 2015	1,280	1,161
Other current assets	3,438	4,712
Total current assets	16,190	15,711
Property and equipment, net	1,505	1,384
Long-term investment securities	2,203	1,843
Goodwill	3,272	3,265
Other long-term assets	2,226	2,475
Total assets	$ 25,396	$ 24,678
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,563	$ 4,976
Trade accounts payable and accrued expenses	2,467	2,212
Book overdraft	212	301
Unearned revenues	280	364
Short-term borrowings	300	299
Total current liabilities	7,822	8,152
Long-term debt	3,792	3,794
Future policy benefits payable	2,834	2,151
Other long-term liabilities	263	235
Total liabilities	14,711	14,332
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,495,007 shares issued at December 31, 2016 and 198,372,059 shares issued at December 31, 2015	33	33
Capital in excess of par value	2,562	2,530
Retained earnings	11,454	11,017
Accumulated other comprehensive (loss) income	(66)	58
Treasury stock, at cost, 49,189,811 shares at December 31, 2016 and 50,084,043 shares at December 31, 2015	(3,298)	(3,292)
Total stockholders' equity	10,685	10,346
Total liabilities and stockholders' equity	$ 25,396	$ 24,678

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions, except per share results)		
Revenues:			
Premiums	$ 53,021	$ 52,409	$ 45,959
Services	969	1,406	2,164
Investment income	389	474	377
Total revenues	54,379	54,289	48,500
Operating expenses:			
Benefits	45,007	44,269	38,166
Operating costs	7,277	7,318	7,639
Depreciation and amortization	354	355	333
Total operating expenses	52,638	51,942	46,138
Income from operations	1,741	2,347	2,362
Gain on sale of business	—	270	—
Interest expense	189	186	192
Income before income taxes	1,552	2,431	2,170
Provision for income taxes	938	1,155	1,023
Net income	$ 614	$ 1,276	$ 1,147
Basic earnings per common share	$ 4.11	$ 8.54	$ 7.44
Diluted earnings per common share	$ 4.07	$ 8.44	$ 7.36
Dividends declared per common share	$ 1.16	$ 1.15	$ 1.11

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Net income	$ 614	$ 1,276	$ 1,147
Other comprehensive (loss) income:			
Change in gross unrealized investment gains/losses	(101)	(114)	122
Effect of income taxes	38	42	(44)
Total change in unrealized investment gains/losses, net of tax	(63)	(72)	78
Reclassification adjustment for net realized gains included in investment income	(96)	(146)	(20)
Effect of income taxes	35	53	7
Total reclassification adjustment, net of tax	(61)	(93)	(13)
Other comprehensive (loss) income, net of tax	(124)	(165)	65
Comprehensive income	$ 490	$ 1,111	$ 1,212

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2014	196,276	$ 33	$ 2,267	$ 8,942	$ 158	$ (2,084)	$ 9,316
Net income				1,147			1,147
Other comprehensive income					65		65
Common stock repurchases			(100)			(772)	(872)
Dividends and dividend equivalents			—	(173)			(173)
Stock-based compensation			98				98
Restricted stock unit vesting	966	—	—			—	—
Stock option exercises	710	—	52				52
Stock option and restricted stock tax benefit			13				13
Balances, December 31, 2014	197,952	33	2,330	9,916	223	(2,856)	9,646
Net income				1,276			1,276
Other comprehensive loss					(165)		(165)
Common stock repurchases			100			(485)	(385)
Dividends and dividend equivalents			—	(175)			(175)
Stock-based compensation			109				109
Restricted stock unit vesting	159	—	(49)			49	—
Stock option exercises	261	—	23				23
Stock option and restricted stock tax benefit			17				17
Balances, December 31, 2015	198,372	33	2,530	11,017	58	(3,292)	10,346
Net income				614			614
Other comprehensive loss					(124)		(124)
Common stock repurchases			—			(104)	(104)
Dividends and dividend equivalents			—	(177)			(177)
Stock-based compensation			115				115
Restricted stock unit vesting	13	—	(98)			98	—
Stock option exercises	110	—	13				13
Stock option and restricted stock tax benefit			2				2
Balances, December 31, 2016	198,495	$ 33	$ 2,562	$ 11,454	$ (66)	$ (3,298)	$ 10,685

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Cash flows from operating activities			
Net income	$ 614	$ 1,276	$ 1,147
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of business	—	(270)	—
Depreciation	388	354	328
Amortization	77	93	121
Stock-based compensation	115	109	98
Net realized capital gains	(96)	(146)	(20)
Benefit for deferred income taxes	(71)	(2)	(64)
Provision for doubtful accounts	39	61	32
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(158)	(180)	(264)
Other assets	426	(872)	(952)
Benefits payable	(413)	501	582
Other liabilities	937	(129)	413
Unearned revenues	(84)	3	155
Other	162	70	42
Net cash provided by operating activities	1,936	868	1,618
Cash flows from investing activities			
Acquisitions, net of cash acquired	(7)	(38)	(18)
Proceeds from sale of business	—	1,061	72
Purchases of property and equipment	(527)	(523)	(528)
Proceeds from sales of property and equipment	—	1	—
Purchases of investment securities	(6,566)	(6,739)	(2,883)
Maturities of investment securities	1,426	1,065	885
Proceeds from sales of investment securities	4,312	5,493	2,409
Net cash (used in) provided by investing activities	(1,362)	320	(63)
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	1,093	(296)	(919)
Proceeds from issuance of senior notes, net	—	—	1,733
(Repayments) proceeds from issuance of commercial paper, net	(2)	298	—
Repayment of long-term debt	—	—	(500)
Common stock repurchases	(104)	(385)	(872)
Dividends paid	(177)	(172)	(172)
Excess tax benefit from stock-based compensation	—	15	12
Change in book overdraft	(89)	(33)	(69)
Proceeds from stock option exercises and other, net	11	21	29
Net cash provided by (used in) financing activities	732	(552)	(758)
Increase in cash and cash equivalents	1,306	636	797
Cash and cash equivalents at beginning of year	2,571	1,935	1,138
Cash and cash equivalents at end of year	$ 3,877	$ 2,571	$ 1,935
Supplemental cash flow disclosures:			
Interest payments	$ 185	$ 187	$ 143
Income tax payments, net	$ 916	$ 1,179	$ 1,030
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 7	$ 38	$ 18
Less: Fair value of liabilities assumed	—	—	—

Cash paid for acquired businesses, net of cash acquired	$ 7	$ 38	$ 18

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 75% of our total premiums and services revenue from contracts with the federal government in 2016, including 14% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidated the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, future policy benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

Certain amounts have been reclassified to conform to the current year presentation.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

On July 21, 2016, the U.S. Department of Justice and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges coupled with three premium stabilization programs, as described more fully below.

The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. See Note 7 for detail regarding amounts paid for the annual health insurer fee.

The Health Care Reform Law also establishes risk spreading premium stabilization programs effective January 1, 2014. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately 16% of our total premiums and services revenue for the year ended December 31, 2016, a subset of which is subject to these programs. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state

average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law. We refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there will be no payments associated with these audits for 2015, the pilot year for the audits.

The temporary risk corridor program applies to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including our small group health plans, were not subject to the risk corridor program. The risk corridor provisions limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to us or require us to refund HHS a portion of the premiums we received.

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, and ceased recognizing revenues under the risk corridor program as discussed further in Note 7.

The transitional reinsurance program required us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the Health Care Reform Law in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we account for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in our consolidated statements of income. We account for contributions made by individual commercial plans compliant with the Health Care Reform Law, which are subject to recoveries, as ceded premiums (a reduction of premiums) and similarly we account for any recoveries as ceded benefits (a reduction of benefits expense) in our consolidated statements of income.

We were required to remit payment for our per member reinsurance contribution, exclusive of the portion payable to the U.S. Treasury, by January 15 of the year following the coverage year, or January 15, 2017 for the 2016 coverage year. The portion of the reinsurance contribution due to the U.S. Treasury must be paid by November 15 of the year following the coverage year, or November 15, 2017 for the 2016 coverage year. Risk adjustment calculations will be completed and HHS will notify us of recoveries due or payments owed to/from us under the risk adjustment and reinsurance programs by June 30 of the year following the coverage year. Following this notification, risk corridor calculations are then due by July 31 of the year following the coverage year. Payments due to HHS under the risk adjustment and risk corridor programs must be remitted within 30 days of notification for each program and will be collected prior to the distribution of recoveries by HHS under each program. Payment and recovery amounts associated

with reinsurance and risk adjustment will generally be settled with HHS annually in the year following the coverage year. Accordingly, for the 2016 coverage year, we expect to receive recoveries and/or pay amounts due under these programs in 2017.

See Note 7 for detail regarding amounts recorded to the consolidated balance sheets related to the 3Rs.

In addition to the provisions discussed above, beginning in 2014, HHS pays us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. We account for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We do not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity is accumulated at the state and legal entity level and recorded in our consolidated balance sheet in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the coverage year. For 2016, payments to HHS associated with cost sharing subsidies for which we do not assume risk were approximately $373 million, exceeding receipts of $345 million by $28 million. For 2015, receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $478 million, exceeding payments of $409 million by $69 million. For 2014, receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $281 million, exceeding payments of $255 million by $26 million.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets. Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with

respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions. Individual polices are subject to the requirements of the Health Care Reform Law as discussed previously.

Premiums Revenue

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership and changes in risk corridor estimates are recognized when the amounts become determinable and the collectibility is reasonably assured.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the individual, small group, and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Medicare Advantage products are also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2016, subsidy and discount reimbursements of $11.1 billion exceeded payments of $10.0 billion by $1.1 billion. For 2015, subsidy and discount payments of $8.9 billion exceeded reimbursements of $8.6 billion by $361 million. For 2014, subsidy and discount payments of $6.7 billion exceeded reimbursements of $5.8 billion by $945 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 6 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to employer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectibility of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

Under our current TRICARE South Region contract with the Department of Defense, we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. The current contract includes fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with the current contract. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2016, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $25 million for the year. For 2015, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $4 million for the year. For 2014, health care cost reimbursements and payments were each $3.2 billion.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 6, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates was $889 million at December 31, 2016 and $723 million at December 31, 2015.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Life insurance, annuities, and certain health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model and accordingly policy acquisition costs are expensed as incurred because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the recognition of previously deferred acquisition costs.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 5 years for computer software, and 10 to 20 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and other intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted

future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Goodwill and Other Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2016, 2015, and 2014 did not result in an impairment loss.

Other intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Other intangible assets are amortized over the useful life, based upon the pattern of future cash flows attributable to the asset. This sometimes results in an accelerated method of amortization for customer contracts because the asset tends to dissipate at a more rapid rate in earlier periods. Other than customer contracts, other intangible assets generally are amortized using the straight-line method. We review other finite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent two months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent two months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, and epidemics also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In the fourth quarter of 2015, we recognized a premium deficiency reserve of $176 million for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year and recorded a change in estimate of $208 million in the second quarter of 2016 associated with the 2016 coverage year as discussed in more detail in Note 7. As of December 31, 2016, we had no remaining premium deficiency reserve.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. During 2016, we recorded a loss for a premium deficiency as discussed further in Note 18.

We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed previously, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the release of reserves for future policy benefits.

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as

deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida, Texas and Georgia. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us beginning in 2018 as well as a call option that would allow us to purchase the controlling interest beginning in 2021. Accordingly, we recorded, at fair value, a liability and an asset associated with the put and call, respectively. Changes in the fair value of the liability and asset during the years ended December 31, 2016, 2015, and 2014 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2016, 2015, or 2014.

Related Party

As noted above, MCCI is a related party to Humana. In December 2015, we purchased a note receivable directly from a third-party bank syndicate related to the financing of MCCI's business and extended the exercise date of the put option to 2018 and the call option to 2021. The note balance was $314 million at December 31, 2016 and $284 million at December 31, 2015. The note receivable bears interest at 10% annually, payable in quarterly installments, and matures in December 2020. We have also entered into a revolving note agreement providing a line of credit up to $55 million under which no balance is outstanding at December 31, 2016. The note receivable is included with other long-term assets in our consolidated balance sheet and with purchases of investment securities in our consolidated statement of cash flows. The related interest income of $30 million for 2016 is included in investment income in our consolidated statement of income. The interest was accrued to the loan balance during 2016 pursuant to the terms of the note. MCCI provides services to Humana Medicare Advantage members under capitation contracts with our health plans. Under these capitation agreements with Humana, MCCI assumes the financial risk associated with these Medicare Advantage members. We also have an outstanding advance to MCCI of approximately $6 million at December 31, 2016, with repayment terms tied to the performance under the capitation agreements. We recognized benefits expense of approximately $1.1 billion in 2016, $1.0 billion in 2015 and $962 million in 2014 under these capitation agreements with MCCI.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. However, prior to July 2, 2015, for awards granted to retirement eligible employees, compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. For awards granted on or after July 2, 2015 to retirement eligible employees, we recognize expense on a straight-line basis over the service period (the vesting period). We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate

the grant-date fair value of stock options using the Black-Scholes option-pricing model. Prior to 2016 we reported certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. In 2016, we prospectively applied the provisions of new guidance issued by the Financial Accounting Standards Board, or FASB, related to the presentation of windfall tax benefits as cash flows from operating activities which resulted in reclassifying $20 million of cash flows from financing activities to operating activities for the three months ended March 31, 2016. We elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period.

Additional detail regarding our stock-based compensation plans is included in Note 13.

Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares, or units, using the treasury stock method.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment advisor. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities, as well as auction rate securities, are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows. Auction rate securities are debt instruments with interest rates that reset through periodic short-term auctions. From time to time, liquidity issues in the credit markets have led to failed auctions. Given the liquidity issues, fair value could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In March 2016, the FASB issued new guidance related to accounting for employee share-based payments, which changes how income tax effects of share-based payments are recorded as well as the minimum statutory tax withholding requirements and allows an accounting policy election to recognize forfeitures when they occur. As permitted, we elected to early adopt this new guidance during the second quarter of 2016 prospectively effective January 1, 2016. The adoption of this new guidance resulted in the recognition of approximately $20 million, or $0.12 per diluted common share, of tax benefits in net income in our consolidated statement of income for the three months ended March 31, 2016 that had previously been recorded as additional paid-in capital in our condensed consolidated balance sheet. We also prospectively applied the provisions of the new guidance related to the presentation of windfall tax benefits as cash flows from operating activities which resulted in reclassifying $20 million of cash flows from financing activities to operating activities for the three months ended March 31, 2016. We elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period.

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. The new guidance is effective for us beginning with annual and interim periods in 2017, with early adoption permitted. We elected to early adopt the guidance and have classified all deferred tax liabilities and assets as noncurrent in our consolidated balance sheet at December 31, 2015 to simplify their presentation. The adoption of the new guidance did not have any impact on our results of operations or cash flows.

In May 2015, the FASB issued new guidance requiring insurance entities to provide additional disclosures about claim liabilities including paid claims development information by accident year and claim frequency data and related methodologies. We adopted this new guidance in this 2016 Form 10-K. The applicable disclosures are included in this Note 2 and Note 10.

In March 2015, the FASB issued new guidance which changes the presentation of debt issuance costs from an asset to a direct reduction of the related debt liability. We adopted this new guidance on January 1, 2016 on a retrospective basis by directly deducting unamortized debt issuance costs from long-term debt on our balance sheet for all periods presented. Debt issuance costs had previously been classified in our balance sheet as other long-term assets.

Accounting Pronouncements Effective in Future Periods

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance is effective for us beginning January 1, 2019. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio

consists of available for sale debt securities. We are currently evaluating the impact on our results of operations, financial condition, or cash flows.

In February 2016, the FASB issued new guidance related to accounting for leases which requires lessees to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). The new guidance is effective for us beginning with annual and interim periods in 2019, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We have begun the process of identifying the population of lease agreements and other arrangements that may contain embedded leases for purposes of adopting the new standard. While we expect to record significant leased assets and corresponding lease obligations based on our existing population of individual leases, we continue to evaluate the impact on our results of operations, financial position and cash flows.

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. Accordingly, our premiums revenue and investment income, collectively representing approximately 98% of our consolidated external revenues for 2016, are not included in the scope of the new guidance. We are analyzing how we may recognize revenue under the new guidance by reviewing selected sample contracts presently in place. The new guidance is effective for us beginning with annual and interim periods in 2018. While we expect revenue related to our Pharmacy, Provider Services, ASO and other services businesses to remain primarily unchanged, we are still evaluating the impact of the new guidance on the customer arrangements for these businesses. Accordingly, we continue to evaluate the impact of the new standard on our results of operations, financial condition and cash flows.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS AND DIVESTITURES

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million which is reported as gain on sale of business in the accompanying consolidated statements of income for the year ended December 31, 2015. The accompanying consolidated statements of income include revenues related to Concentra of $411 million in 2015 and $998 million in 2014.

During 2016, 2015 and 2014, we acquired health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our condensed consolidated statements of income and condensed consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2016, 2015, and 2014 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2016 and 2015, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2016				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 800	$ 1	$ (15)	$ 786
Mortgage-backed securities	1,662	6	(31)	1,637
Tax-exempt municipal securities	3,358	15	(68)	3,305
Mortgage-backed securities:				
Residential	9	—	—	9
Commercial	307	1	(4)	304
Asset-backed securities	160	—	—	160
Corporate debt securities	3,530	145	(78)	3,597
Total debt securities	$ 9,826	$ 168	$ (196)	$ 9,798
December 31, 2015				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 331	$ 2	$ (1)	$ 332
Mortgage-backed securities	1,902	12	(23)	1,891
Tax-exempt municipal securities	2,611	61	(4)	2,668
Mortgage-backed securities:				
Residential	13	—	—	13
Commercial	1,024	2	(41)	985
Asset-backed securities	264	1	(2)	263
Corporate debt securities	2,873	140	(55)	2,958
Total debt securities	$ 9,018	$ 218	$ (126)	$ 9,110

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2016 and 2015, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2016						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 697	$ (15)	$ 3	$ —	$ 700	$ (15)
Mortgage-backed securities	1,528	(31)	3	—	1,531	(31)
Tax-exempt municipal securities	2,756	(67)	43	(1)	2,799	(68)
Mortgage-backed securities:						
Residential	—	—	4	—	4	—
Commercial	182	(3)	24	(1)	206	(4)
Asset-backed securities	51	—	63	—	114	—
Corporate debt securities	1,544	(71)	69	(7)	1,613	(78)
Total debt securities	$ 6,758	$ (187)	$ 209	$ (9)	$ 6,967	$ (196)
December 31, 2015						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 195	$ (1)	$ 14	$ —	$ 209	$ (1)
Mortgage-backed securities	1,484	(20)	86	(3)	1,570	(23)
Tax-exempt municipal securities	843	(3)	52	(1)	895	(4)
Mortgage-backed securities:						
Residential	2	—	4	—	6	—
Commercial	626	(13)	265	(28)	891	(41)
Asset-backed securities	258	(2)	—	—	258	(2)
Corporate debt securities	918	(45)	63	(10)	981	(55)
Total debt securities	$ 4,326	$ (84)	$ 484	$ (42)	$ 4,810	$ (126)

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2016. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2016, 8% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 46% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 54% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 11%. In addition, 4% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

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Residential mortgage back securities comprised approximately 99% of our agency mortgage-backed securities at December 31, 2016 and 98% at December 31, 2015.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2016 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2016.

The percentage of corporate securities associated with the financial services industry was 23% at December 31, 2016 and 25% at December 31, 2015.

Our unrealized loss from all securities was generated from approximately 990 positions out of a total of approximately 2,140 positions at December 31, 2016. All issuers of securities we own that were trading at an unrealized loss at December 31, 2016 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2016, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2016.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2016, 2015, and 2014:

	2016	2015	2014
		(in millions)	
Gross realized gains	$ 120	$ 179	$ 29
Gross realized losses	(24)	(33)	(9)
Net realized capital gains	$ 96	$ 146	$ 20

There were no material other-than-temporary impairments in 2016, 2015, or 2014.

The contractual maturities of debt securities available for sale at December 31, 2016, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 635	$ 635
Due after one year through five years	2,424	2,426
Due after five years through ten years	1,938	1,893
Due after ten years	2,691	2,734
Mortgage and asset-backed securities	2,138	2,110
Total debt securities	$ 9,826	$ 9,798

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2016 and 2015, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2016				
Cash equivalents	$ 3,654	$ 3,654	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	786	—	786	—
Mortgage-backed securities	1,637	—	1,637	—
Tax-exempt municipal securities	3,305	—	3,302	3
Mortgage-backed securities:				
Residential	9	—	9	—
Commercial	304	—	304	—
Asset-backed securities	160	—	160	—
Corporate debt securities	3,597	—	3,593	4
Total debt securities	9,798	—	9,791	7
Total invested assets	$ 13,452	$ 3,654	$ 9,791	$ 7
December 31, 2015				
Cash equivalents	$ 2,229	$ 2,229	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	332	—	332	—
Mortgage-backed securities	1,891	—	1,891	—
Tax-exempt municipal securities	2,668	—	2,663	5
Mortgage-backed securities:				
Residential	13	—	13	—
Commercial	985	—	985	—
Asset-backed securities	263	—	263	—
Corporate debt securities	2,958	—	2,952	6
Total debt securities	9,110	—	9,099	11
Total invested assets	$ 11,339	$ 2,229	$ 9,099	$ 11

There were no material transfers between Level 1 and Level 2 during 2016 or 2015.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our Level 3 assets had a fair value of $7 million at December 31, 2016, or 0.1% of our total invested assets. During the years ended December 31, 2016, 2015, and 2014, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2016			2015			2014		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$ 6	$ 5	$ 11	$ 24	$ 8	$ 32	$ 24	$ 13	$ 37
Total gains or losses:									
Realized in earnings	—	—	—	(1)	—	(1)	—	—	—
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	—	—	—	(17)	(3)	(20)	—	(5)	(5)
Settlements	(2)	(2)	(4)	—	—	—	—	—	—
Balance at December 31	$ 4	$ 3	$ 7	$ 6	$ 5	$ 11	$ 24	$ 8	$ 32

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $3,792 million at December 31, 2016 and $3,794 million at December 31, 2015. The fair value of our long-term debt was $4,004 million at December 31, 2016 and $3,986 million at December 31, 2015. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for our commercial paper borrowings.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisition of certain health and wellness related businesses during 2016, 2015, and 2014. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2016, 2015, or 2014.

6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2016 and 2015. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	2016		2015	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 8	$ 1,001	$ 25	$ 2,082
Trade accounts payable and accrued expenses	(158)	(128)	(47)	(63)
Net current (liability) asset	$ (150)	$ 873	$ (22)	$ 2,019

7. HEALTH CARE REFORM

Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 that we believed would improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results that included the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment in the fourth quarter of 2015 of the profitability of our individual commercial medical policies compliant with the Health Care Reform Law, we recorded in that quarter a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million in benefits payable in our consolidated balance sheet with a corresponding increase in benefits expense in our consolidated statement of income. As noted in the table below, in the second quarter of 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense in our condensed consolidated statement of income primarily as a result of currently and projected unfavorable claims experience.

Changes in the premium deficiency reserve for the 2016 coverage year for the years ended December 31, 2016 and 2015 were as follows. There was no premium deficiency reserve in 2014.

	Premium Deficiency Reserve For the years ended December 31,	
	2016	2015
	(in millions)	
Balance at January 1	176	$ —
Current period results applied to the PDR liability for the 2016 coverage year	(384)	—
Change in full year estimate recorded in benefits expense	208	176
Balance at December 31	$ —	$ 176

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2016, we collected approximately $36 million from CMS for risk corridor receivables associated with

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program.

On February 14, 2017, we announced we are exiting our individual commercial medical businesses January 1, 2018. As discussed previously, we have worked over the past several years to address market and programmatic challenges in order to keep coverage options available wherever we could offer a viable product. This has included pursuing business changes, such as modifying networks, restructuring product offerings, reducing the company's geographic footprint and increasing premiums. All of these actions were taken with the expectation that our individual commercial medical business would stabilize to the point where we could continue to participate in the program. However, based on our initial analysis of data associated with our healthcare exchange membership following the 2017 open enrollment period, we are seeing further signs of an unbalanced risk pool. Therefore, we have decided that we cannot continue to offer this coverage for 2018.

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2016 and December 31, 2015. Amounts classified as long-term represent settlements that we expect to exceed 12 months at December 31, 2016.

	2016			2015		
	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
	(in millions)					
Prior Coverage Years						
Premiums receivable	$ —	$ —	$ —	$ 126	$ —	$ —
Other current assets	—	54	—	—	610	—
Trade accounts payable and accrued expenses	—	—	—	(223)	—	—
Net current asset (liability)	—	54	—	(97)	610	—
Other long-term assets	—	—	—	10	—	459
Total prior coverage years' net asset (liability)	—	54	—	(87)	610	459
Current Coverage Year						
Premiums receivable	307	—	—	—	—	—
Other current assets	—	206	—	—	—	—
Trade accounts payable and accrued expenses	(117)	—	—	—	—	—
Net current asset	190	206	—	—	—	—
Other long-term assets	6	—	—	—	—	—
Total current coverage year net asset	196	206	—	—	—	—
Total net asset (liability)	$ 196	$ 260	$ —	$ (87)	$ 610	$ 459

Changes in estimate of the risk adjustment and reinsurance receivables and payables for prior coverage years primarily result from the annual June 30 notification from CMS of risk adjustment and reinsurance settlement amounts. These changes in estimate were substantially offset by changes in estimate of risk corridor receivables that were subsequently written off in the fourth quarter of 2016 as discussed above. During 2016, net collections under the 3Rs associated with prior coverage years were $383 million. We expect to collect the remaining $54 million of reinsurance recoverables related to prior coverage years in 2017.

To the extent certain provisions of the Health Care Reform Law are successfully challenged in court or there are changes in legislation or the application of legislation, there can be no guarantee that receivables established under the reinsurance or risk adjustment provisions of the Health Care Reform Law will ultimately be collected. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

In 2016, we paid the federal government $916 million for the annual health insurance industry fee attributed to calendar year 2016, compared to $867 million in 2015 and $562 million in 2014, in accordance with the Health Care Reform Law. This fee is not deductible for tax purposes. The annual health insurance industry fee has been suspended for calendar year 2017 but is scheduled to resume in calendar year 2018.

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2016 and 2015.

	2016	2015
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	681	633
Equipment	750	645
Computer software	1,744	1,424
	3,195	2,722
Accumulated depreciation	(1,690)	(1,338)
Property and equipment, net	$ 1,505	$ 1,384

Depreciation expense was $388 million in 2016, $354 million in 2015, and $328 million in 2014, including amortization expense for capitalized internally developed and purchased software of $255 million in 2016, $220 million in 2015, and $191 million in 2014.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2016 and 2015 were as follows:

	Retail	Group	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2015	$ 1,069	$ 385	$ 1,777	$ 3,231
Acquisitions	—	—	35	35
Dispositions	—	—	(1)	(1)
Balance at December 31, 2015	1,069	385	1,811	3,265
Acquisitions	—	—	7	7
Balance at December 31, 2016	$ 1,069	$ 385	$ 1,818	$ 3,272

Healthcare Services segment goodwill of $480 million associated with the sale of Concentra was included with assets-held-for sale as of January 1, 2015 and is excluded from the table above. This $480 million of goodwill was disposed of on June 1, 2015 with the completion of the sale of Concentra.

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The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2016 and 2015.

	Weighted Average Life	2016			2015		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
		(in millions)					
Other intangible assets:							
Customer contracts/relationships	9.8 years	$ 566	$ 347	$ 219	$ 566	$ 292	$ 274
Trade names and technology	8.3 years	104	69	35	104	54	50
Provider contracts	14.7 years	51	29	22	51	24	27
Noncompetes and other	8.2 years	32	28	4	32	26	6
Total other intangible assets	9.9 years	$ 753	$ 473	$ 280	$ 753	$ 396	$ 357

Amortization expense for other intangible assets was approximately $77 million in 2016, $93 million in 2015, and $121 million in 2014. The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2017	$ 71
2018	63
2019	52
2020	48
2021	14

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

10. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Balances at January 1	$ 4,976	$ 4,475	$ 3,893
Less: Premium deficiency reserve	(176)	—	—
Less: Reinsurance recoverables	(85)	(78)	—
Balances at January 1, net	4,715	4,397	3,893
Incurred related to:			
Current year	45,318	44,397	38,641
Prior years	(582)	(236)	(518)
Total incurred	44,736	44,161	38,123
Paid related to:			
Current year	(40,852)	(39,802)	(34,357)
Prior years	(4,112)	(4,041)	(3,262)
Total paid	(44,964)	(43,843)	(37,619)
Premium deficiency reserve	—	176	—
Reinsurance recoverable	76	85	78
Balances at December 31	$ 4,563	$ 4,976	$ 4,475

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016, $236 million in 2015, and $518 million in 2014. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2016, 2015, and 2014.

	Favorable Medical Claims Reserve Development		
	2016	2015	2014
Retail Segment	$ (535)	$ (228)	$ (488)
Group Segment	(46)	(7)	(29)
Other Businesses	(1)	(1)	(1)
Total	$ (582)	$ (236)	$ (518)

The favorable medical claims reserve development for 2016, 2015, and 2014 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development in 2016 primarily resulted from our Medicare Advantage and individual commercial medical businesses. The decline in favorable prior period development in 2015 primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products. The favorable prior

period development during 2014 resulted from increased membership, better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Premium deficiency reserve for short-duration policies	$ (176)	$ 176	$ —
Military services	8	12	11
Future policy benefits	439	(80)	32
Total	$ 271	$ 108	$ 43

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7.

Military services benefits expense for each year in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described in Note 18. The decrease in benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our Retail and Group segments as of December 31, 2016, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2014 and 2015 is presented as supplementary information.

For both our Retail and Group segments, claims frequency is measured as medical fee-for-service claims for each service encounter with a unique provider identification number. Our claims frequency measure includes claims covered by deductibles as well as claims under capitated arrangements. Claim counts may vary based on product mix and the percentage of delegated capitation arrangements.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Balances at January 1	$ 4,296	$ 3,879	$ 3,268
Less: Premium deficiency reserve	(176)	—	—
Less: Reinsurance recoverables	(85)	(78)	—
Balances at January 1, net	4,035	3,801	3,268
Incurred related to:			
Current year	40,854	39,760	33,996
Prior years	(535)	(228)	(488)
Total incurred	40,319	39,532	33,508
Paid related to:			
Current year	(36,967)	(35,835)	(30,305)
Prior years	(3,487)	(3,463)	(2,670)
Total paid	(40,454)	(39,298)	(32,975)
Premium deficiency reserve	—	176	—
Reinsurance recoverable	76	85	78
Balances at December 31	$ 3,976	$ 4,296	$ 3,879

At December 31, 2016, benefits payable for our Retail segment included IBNR of approximately $2.9 billion, primarily associated with claims incurred in 2016. The cumulative number of reported claims as of December 31, 2016 was approximately 87.7 million for claims incurred in 2016, 88.8 million for claims incurred in 2015, and 74.3 million for claims incurred in 2014.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2016, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2014 Unaudited	2015 Unaudited	2016
		(in millions)	
2014	$ 33,996	$ 33,800	$ 33,749
2015	—	39,760	39,289
2016	—	—	40,854
Total			$ 113,892

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Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2014 Unaudited	2015 Unaudited	2016
	(in millions)		
2014	$ 30,305	$ 33,704	$ 33,740
2015		35,835	39,285
2016			36,967
Total			$ 109,992
All outstanding benefit liabilities before 2014, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 3,900

Group Segment

Activity in benefits payable for our Group segment, excluding military services, was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
	(in millions)		
Balances at January 1	$ 600	$ 578	$ 577
Less: Reinsurance recoverables	—	—	—
Balances at January 1, net	600	578	577
Incurred related to:			
Current year	5,160	5,261	5,148
Prior years	(46)	(7)	(29)
Total incurred	5,114	5,254	5,119
Paid related to:			
Current year	(4,605)	(4,671)	(4,574)
Prior years	(546)	(561)	(544)
Total paid	(5,151)	(5,232)	(5,118)
Balances at December 31	$ 563	$ 600	$ 578

At December 31, 2016, benefits payable for our Group segment included IBNR of approximately $468 million, primarily associated with claims incurred in 2016. The cumulative number of reported claims as of December 31, 2016 was approximately 23.3 million for claims incurred in 2016, 29.1 million for claims incurred in 2015, and 27.3 million for claims incurred in 2014.

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The following tables provide information about incurred and paid claims development for the Group segment as of December 31, 2016, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2014 Unaudited	2015 Unaudited	2016
	(in millions)		
2014	$ 5,148	$ 5,135	$ 5,135
2015	—	5,261	5,217
2016	—	—	5,160
Total			$ 15,512

	Cumulative Paid Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2014 Unaudited	2015 Unaudited	2016
	(in millions)		
2014	$ 4,574	$ 5,126	$ 5,134
2015		4,671	5,210
2016			4,605
Total			$ 14,949
All outstanding benefit liabilities before 2014, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 563

Reconciliation to Consolidated

The reconciliation of the net incurred and paid claims development tables to benefits payable in the consolidated statement of financial position is as follows:

	December 31, 2016
Net outstanding liabilities	
Retail	$ 3,900
Group	563
Other insurance lines	24
Benefits payable, net of reinsurance	4,487
Reinsurance recoverable on unpaid claims	
Retail	76
Group	—
Other insurance lines	—
Total reinsurance recoverable on unpaid claims	76
Total benefits payable, gross	$ 4,563

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Current provision:			
Federal	$ 921	$ 1,067	$ 1,006
States and Puerto Rico	88	90	81
Total current provision	1,009	1,157	1,087
Deferred benefit	(71)	(2)	(64)
Provision for income taxes	$ 938	$ 1,155	$ 1,023

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2016, 2015 and 2014 due to the following:

	2016	2015	2014
		(in millions)	
Income tax provision at federal statutory rate	$ 543	$ 851	$ 759
States, net of federal benefit, and Puerto Rico	41	44	48
Tax exempt investment income	(20)	(24)	(27)
Health insurer fee	336	314	204
Nondeductible executive compensation	30	18	22
Concentra sale	—	(67)	—
Other, net	8	19	17
Provision for income taxes	$ 938	$ 1,155	$ 1,023

The provision for income taxes for 2016, 2015, and 2014 reflects a $30 million, $18 million, and $22 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled. Principal components of our net deferred tax balances at December 31, 2016 and 2015 were as follows.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Assets (Liabilities)	
	2016	2015
	(in millions)	
Future policy benefits payable	$ 355	$ 200
Benefits payable	196	267
Compensation and other accrued expenses	153	130
Net operating loss carryforward	52	47
Deferred acquisition costs	72	64
Unearned revenues	18	22
Investment securities	12	—
Other	6	13
Total deferred income tax assets	864	743
Valuation allowance	(49)	(42)
Total deferred income tax assets, net of valuation allowance	815	701
Depreciable property and intangible assets	(363)	(363)
Prepaid expenses	(53)	(45)
Investment securities	—	(37)
Total deferred income tax liabilities	(416)	(445)
Total net deferred income tax assets	$ 399	$ 256
Amounts recognized in the consolidated balance sheets:		
Other long-term assets	$ 399	$ 256

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. We elected to early adopt the guidance and have classified all deferred tax liabilities and assets as noncurrent in our consolidated balance sheets at December 31, 2016 and 2015 to simplify their presentation.

At December 31, 2016, we had approximately $138 million of net operating losses to carry forward related to prior acquisitions and our Puerto Rico subsidiaries. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2017 through 2033. Due to limitations and uncertainty regarding our ability to use some of the carryforwards, a valuation allowance was established on $126 million of these net operating loss carryforwards and $4 million of other items related to Puerto Rico. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We provide for income taxes on the undistributed earnings of our Puerto Rico operations using that jurisdiction's tax rate, which has been lower historically than the U.S. statutory tax rate. Permanent investment of these earnings has resulted in cumulative unrecognized deferred tax liabilities of approximately $30 million as of December 31, 2016.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2014 and prior years. Our 2015 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Our 2016 tax return is under advance review by the IRS under CAP. With few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2013. We are not aware of any material adjustments that may be proposed.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

12. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2016 and 2015:

	2016	2015
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 7.20% due June 15, 2018	$ 501	$ 502
$300 million, 6.30% due August 1, 2018	304	307
$400 million, 2.625% due October 1, 2019	398	398
$600 million, 3.15% due December 1, 2022	595	595
$600 million, 3.85% due October 1, 2024	595	595
$250 million, 8.15% due June 15, 2038	264	263
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	738
Total long-term debt	$ 3,792	$ 3,794

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the $500 million 6.45% senior unsecured notes as discussed below.

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of these notes which is included in interest expense in the consolidated statement of income.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes (other than the 6.30% senior notes) contain a change of control provision that may require us to purchase the notes under certain circumstances.

Prior to 2009, we were parties to interest-rate swap agreements that exchanged the fixed interest rate under our senior notes for a variable interest rate based on LIBOR. As a result, the carrying value of the senior notes was adjusted to reflect changes in value caused by an increase or decrease in interest rates. During 2008, we terminated all of our swap agreements. The cumulative adjustment to the carrying value of our senior notes was $103 million as of the termination date which is being amortized as a reduction to interest expense over the remaining term of the senior notes. In October 2014, the redemption of our 6.45% senior notes reduced the unamortized carrying value adjustment by $12 million. The unamortized carrying value adjustment was $23 million as of December 31, 2016 and $28 million as of December 31, 2015.

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 100 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 12.5 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $9.0 billion at December 31, 2016 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $10.7 billion and an actual leverage ratio of 1.4:1, as measured in accordance with the credit agreement as of December 31, 2016. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2016, we had no borrowings outstanding under the credit agreement and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2016, we had $1 billion of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amount outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2016 was $475 million, with $300 million outstanding at December 31, 2016, compared to $299 million outstanding at December 31, 2015.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $196 million in 2016, $188 million in 2015, and $176 million in 2014. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $204.03 on December 31, 2016, approximately 13% of the retirement and savings plan's assets were invested in our common stock, or approximately 2.5 million shares, representing 2% of the shares outstanding as of December 31, 2016. At December 31, 2016, approximately 2.8 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. For awards granted prior to July 2, 2015, our equity award agreements generally contain provisions whereby the awards automatically accelerate and vest upon change in control, including those granted to retirement-eligible participants described below. Awards granted on or after July 2, 2015 would generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants granted prior to July 2, 2015 generally will continue to fully vest on the originally scheduled vest date upon retirement from the Company. For stock awards of retirement-eligible employees granted on or after July 2, 2015, awards are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2016, 2015, and 2014:

	2016	2015	2014
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 106	$ 99	$ 91
Stock options	9	10	7
Total stock-based compensation expense	115	109	98
Tax benefit recognized	(20)	(26)	(22)
Stock-based compensation expense, net of tax	$ 95	$ 83	$ 76

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $53 million in 2016, $34 million in 2015, and $30 million in 2014. There was no capitalized stock-based compensation expense during these years.

At December 31, 2016, there were 16.4 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 7.1 million shares of common stock available for future grants assuming all stock options were granted or 3.1 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests three years from the date of grant. Restricted stock granted on or after July 2, 2015, generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock units also include performance-based conditions generally associated with strategic membership growth and return on invested capital. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $168.12 in 2016, $165.26 in 2015, and $103.57 in 2014. Activity for our restricted stock was as follows for the year ended December 31, 2016:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2015	3,365	$ 104.58
Granted	656	168.12
Vested	(1,455)	87.77
Forfeited	(74)	135.32
Nonvested restricted stock at December 31, 2016	2,492	$ 121.94

Approximately 27% of the nonvested restricted stock at December 31, 2016 included performance-based conditions.

The fair value of shares vested was $253 million during 2016, $153 million during 2015, and $99 million during 2014. Total compensation expense not yet recognized related to nonvested restricted stock was $97 million at December 31, 2016. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2016, 2015, and 2014 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2016	2015	2014
Weighted-average fair value at grant date	$ 37.12	$ 36.91	$ 22.45
Expected option life (years)	4.2 years	4.2 years	4.3 years
Expected volatility	27.6%	27.4%	27.6%
Risk-free interest rate at grant date	1.1%	1.4%	1.3%
Dividend yield	0.7%	0.7%	1.1%

When valuing employee stock options, we stratify the employee population into three homogeneous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2016:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2015	835	$ 121.89
Granted	362	167.81
Exercised	(161)	86.86
Forfeited	(14)	163.94
Options outstanding at December 31, 2016	1,022	$ 143.04
Options exercisable at December 31, 2016	342	$ 111.28

As of December 31, 2016, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $62 million, and a weighted-average remaining contractual term of 4.9 years. As of December 31, 2016, exercisable stock options had an aggregate intrinsic value of $32 million, and a weighted-average remaining contractual term of 3.8 years. The total intrinsic value of stock options exercised during 2016 was $18 million, compared with $28 million during 2015 and $32 million during 2014. Cash received from stock option exercises totaled $14 million in 2016, $23 million in 2015, and $52 million in 2014.

Total compensation expense not yet recognized related to nonvested options was $14 million at December 31, 2016. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 614	$ 1,276	$ 1,147
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	149,375	149,455	154,187
Dilutive effect of:			
Employee stock options	219	192	230
Restricted stock	1,323	1,495	1,457
Shares used to compute diluted earnings per common share	150,917	151,142	155,874
Basic earnings per common share	$ 4.11	$ 8.54	$ 7.44
Diluted earnings per common share	$ 4.07	$ 8.44	$ 7.36
Number of antidilutive stock options and restricted stock awards excluded from computation	748	415	320

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

15. STOCKHOLDERS' EQUITY

As discussed in Note 2, we elected to early adopt new guidance related to accounting for employee share-based payments prospectively effective January 1, 2016. The adoption of this new guidance resulted in the recognition of approximately $20 million of tax benefits in net income in our consolidated statement of income for the three months ended March 31, 2016 that had previously been recorded as additional paid-in capital in our consolidated balance sheet.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2014, 2015, and 2016 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2014	$1.10	$170
2015	$1.14	$170
2016	$1.16	$172

Under the terms of the Merger Agreement, we agreed with Aetna that our quarterly dividend would not exceed $0.29 per share prior to the closing or termination of the Merger. On October 26, 2016, the Board declared a cash dividend of $0.29 per share that was paid on January 27, 2017 to stockholders of record on January 12, 2017, for an aggregate amount of $43 million.

On February 14, 2017, following the termination of the Merger Agreement, the Board declared a cash dividend of $0.40 per share, to be paid on April 28, 2017, to the stockholders of record on March 31, 2017. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Repurchases

In September 2014, our Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with an authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, which expired on December 31, 2016. Under the share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. Pursuant to the Merger Agreement, after July 2, 2015, we were prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we suspended our share repurchase program.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017.

Excluding shares acquired in connection with employee stock plans as well as 0.36 million shares received in March 2015 upon final settlement of our accelerated share repurchase agreement, or ASR Agreement, described below, for which no cash was paid during the period, share repurchases were as follows during the years ended December 31, 2015 and 2014. Excluding shares acquired in connection with employee stock plans, there were no share repurchases in 2016.

		Year Ended December 31,			
		2015		2014	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost
		(in millions)			
September 2014	$ 2,000	1.85	$ 329	4.10	$ 635 (a)
April 2014	1,000	—	—	1.50	184
April 2013	1,000	—	—	0.10	11
Total repurchases		1.85	$ 329	5.70	$ 830

(a) Includes $100 million held back by Goldman Sachs pending final settlement of the ASR Agreement in March 2015 at which time we received an additional 0.36 million shares which are excluded from the table above.

On November 7, 2014, we announced that we had entered into an accelerated share repurchase agreement, or ASR Agreement, with Goldman, Sachs & Co., or Goldman Sachs, to repurchase $500 million of our common stock as part of the $2 billion share repurchase program authorized in September 2014. Under the ASR Agreement, on November 10, 2014, we made a payment of $500 million to Goldman Sachs from available cash on hand and received an initial delivery of 3.06 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $400 million increase in treasury stock, which reflected the value of the initial 3.06 million shares received upon initial settlement, and a $100 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the ASR Agreement. Upon settlement of the ASR on March 13, 2015, we received an additional 0.36 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement of $146.21, bringing the total shares received under this program to 3.42 million. In addition, upon settlement we reclassified the $100 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

In connection with employee stock plans, we acquired 0.6 million common shares for $104 million in 2016, 0.3 million common shares for $56 million in 2015, and 0.4 million common shares for $42 million in 2014.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.7 billion and $6.6 billion as of December 31, 2016 and 2015, respectively, which exceeded aggregate minimum regulatory requirements of $4.8 billion and $4.6 billion, respectively. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be

reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2017 is approximately $850 million in the aggregate. This compares to dividends that were paid to our parent company in 2016 of approximately $763 million. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2037. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Rent expense	$ 179	$ 201	$ 226
Sublease rental income	(26)	(25)	(14)
Net rent expense	$ 153	$ 176	$ 212

Future annual minimum payments due subsequent to December 31, 2016 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2017	$ 185	$ (19)	$ 166
2018	157	(18)	139
2019	126	(14)	112
2020	81	(11)	70
2021	53	(8)	45
Thereafter	95	(17)	78
Total	$ 697	$ (87)	$ 610

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $184 million in 2017, $108 million in 2018, $48 million in 2019, $5 million in 2020, and $3 million thereafter. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet

arrangements or other contractually narrow or limited purposes. As of December 31, 2016, we were not involved in any SPE transactions.

Guarantees and Indemnifications

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our military services subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our Medicare products, which accounted for approximately 74% of our total premiums and services revenue for the year ended December 31, 2016, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2017, and all of our product offerings filed with CMS for 2017 have been approved.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

Humana Inc.

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CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013, in which two, five, and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2016, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2016, primarily consisted of the TRICARE South Region contract. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On March 30, 2016, we received notice the Defense Health Agency, or DHA, exercised its option to extend the TRICARE South Region contract through March 31, 2017. On July 21, 2016, we were notified by the DHA that we were awarded the contract for the new TRICARE East Region, which is a consolidation of the former North and South Regions, with delivery of health care services expected to commence on October 1, 2017. The next generation East Region and West Region contract awards are currently subject to protests by unsuccessful bidders in the U.S. Court of Federal Claims and before the DHA.

Our state-based Medicaid business accounted for approximately 5% of our total premiums and services revenue for the year ended December 31, 2016. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services

(LTSS), in Illinois and Virginia for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program as well as an Integrated Care Program, or ICP, Medicaid contract in Illinois.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Legal Proceedings and Certain Regulatory Matters

Florida Matters

On January 6, 2012, the Civil Division of the United States Attorney's Office for the Southern District of Florida advised us that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices. On May 1, 2014, the U.S. Attorney's Office filed a Notice of Non-Intervention in connection with a civil qui tam suit related to one of these matters captioned *United States of America ex rel. Olivia Graves v. Plaza Medical Centers, et al.*, and the Court ordered the complaint unsealed. Subsequently, the individual plaintiff amended the complaint and served the Company, opting to continue to pursue the action. The individual plaintiff has filed a fourth amended complaint which we answered on February 19, 2016. The Court has ordered trial to commence on March 6, 2017 if the matter is not resolved prior to trial. We continue to cooperate with and respond to information requests from the U.S. Attorney's office. These matters could result in additional qui tam litigation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided us with an information request, separate from but related to the Plaza Medical matter, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, including the providers identified in the Plaza Medical matter, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice and the U.S. Attorney's Office. These matters are expected to result in additional qui tam litigation.

Litigation Related to the Merger

DOJ Action

On July 21, 2016, the United States government (acting under the U.S. Attorney General), along with the states of Delaware, Florida, Georgia, Illinois, Iowa and Ohio, the commonwealths of Pennsylvania and Virginia, and the District of Columbia, acting by and through their respective attorneys general, filed a civil complaint against us and Aetna in the U.S. District Court for the District of Columbia (we refer to this as the DOJ Action). The complaint alleges, among other things, that the proposed Merger would violate Section 7 of the Clayton Antitrust Act and seeks a permanent injunction to prevent the Merger. The trial commenced on December 5, 2016 and concluded on December 30, 2016. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement.

Shareholder Action

In connection with the Merger, three putative class action complaints were filed by purported Humana stockholders challenging the Merger, two in the Circuit Court of Jefferson County, Kentucky and one in the Court of Chancery of the State of Delaware. The complaints are captioned Solak v. Broussard et al., Civ. Act. No. 15CI03374 (Kentucky

state court), Litwin v. Broussard et al., Civ. Act. No. 15CI04054 (Kentucky state court) and Scott v. Humana Inc. et al., C.A. No. 11323-VCL (Delaware state court). The complaints named as defendants each member of Humana's board of directors, Aetna, and, in the case of the Delaware complaint, Humana. The complaints generally alleged, among other things, that the individual members of our board of directors breached their fiduciary duties owed to our stockholders by entering into the Merger Agreement, approving the mergers as contemplated by the Merger Agreement, and failing to take steps to maximize the value of Humana to our stockholders, and that Aetna, and, in the case of the Delaware complaint, Humana aided and abetted such breaches of fiduciary duties. In addition, the complaints alleged that the merger undervalues Humana, that the process leading up to the execution of the Merger Agreement was flawed, that the members of our board of directors improperly placed their own financial interests ahead of those of our stockholders, and that certain provisions of the Merger Agreement improperly favor Aetna and impede a potential alternative transaction. Among other remedies, the complaints sought equitable relief rescinding the Merger Agreement and enjoining the defendants from completing the mergers as well as costs and attorneys' fees. We refer to all these cases collectively in this report as the Merger Litigation. On August 20, 2015, the parties in the Kentucky state cases filed a stipulation and proposed order with the court to consolidate these cases into a single action captioned In re Humana Inc. Shareholder Litigation, Civ. Act. No. 15CI03374.

On October 9, 2015, solely to avoid the costs, risks, and uncertainties inherent in litigation, and without admitting any liability or wrongdoing, we and the other named defendants in the Merger Litigation signed a memorandum of understanding, which we refer to as the MOU, to settle the Merger Litigation. Subject to court approval and further definitive documentation in a stipulation of settlement that will be subject to customary conditions, the MOU resolved the claims brought in the Merger Litigation and provided that we would make certain additional disclosures related to the proposed mergers. The MOU further provided for, among other things, dismissal of the Merger Litigation with prejudice and a release and settlement by the purported class of our stockholders of all claims against the defendants and their affiliates and agents in connection with the Merger Agreement and transactions and disclosures related to the Merger Agreement. The asserted claims will not be released until such stipulation of settlement receives court approval. The foregoing terms and conditions will be defined by the stipulation of settlement, and class members will receive a separate notice describing the settlement terms and their rights in connection with the approval of the settlement. In connection with the settlement, the parties contemplate that plaintiffs' counsel will file a petition for an award of attorneys' fees and expenses. We will pay or cause to be paid any court awarded attorneys' fees and expenses. There can be no assurance that the parties will ultimately enter into a stipulation of settlement or that a court will approve such settlement even if the parties were to enter into such stipulation. In such event, the proposed settlement as contemplated by the MOU may be terminated. Because the MOU contemplates that the Kentucky court will be asked to approve the settlement, the plaintiffs have already withdrawn the Delaware case.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For example, a number of hospitals and other providers have asserted that, under their network provider contracts, we are not entitled to reduce Medicare Advantage payments to these providers in connection with changes in Medicare payment systems and in accordance with the Balanced Budget and Emergency Deficit Control

Act of 1985, as amended (commonly referred to as "sequestration"). Those challenges have led and could lead to arbitration demands or other litigation. Also, under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do. Penn Treaty is a financially distressed unaffiliated long-term care insurance company. A final court ruling on Penn Treaty's insolvency would trigger a guarantee fund assessment that would result in expense for us, based on current information, estimated at approximately $30 million.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extracontractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

17. SEGMENT INFORMATION

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts, as well as individual commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products. In addition, the Retail segment also includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Group

segment consists of employer group commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products. In addition, our Group segment includes our health and wellness products (primarily marketed to employer groups) and military services business, primarily our TRICARE South Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, home based services, and clinical programs, as well as services and capabilities to advance population health. We will continue to report under the category of Other Businesses those businesses which do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $13.4 billion in 2016, $12.3 billion in 2015, and $9.7 billion in 2014. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $111 million in 2016, $92 million in 2015, and $116 million in 2014.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our segment results were as follows for the years ended December 31, 2016, 2015, and 2014:

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2016						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 31,863	$ —	$ —	$ —	$ —	$ 31,863
Group Medicare Advantage	4,283	—	—	—	—	4,283
Medicare stand-alone PDP	4,009	—	—	—	—	4,009
Total Medicare	40,155	—	—	—	—	40,155
Fully-insured	3,492	5,405	—	—	—	8,897
Specialty	259	1,020	—	—	—	1,279
Medicaid and other	2,640	12	—	38	—	2,690
Total premiums	46,546	6,437	—	38	—	53,021
Services revenue:						
Provider	—	52	226	—	—	278
ASO and other	8	642	—	10	—	660
Pharmacy	—	—	31	—	—	31
Total services revenue	8	694	257	10	—	969
Total revenues—external customers	46,554	7,131	257	48	—	53,990
Intersegment revenues						
Services	—	99	18,842	—	(18,941)	—
Products	—	—	5,993	—	(5,993)	—
Total intersegment revenues	—	99	24,835	—	(24,934)	—
Investment income	101	19	30	66	173	389
Total revenues	46,655	7,249	25,122	114	(24,761)	54,379
Operating expenses:						
Benefits	40,143	5,122	—	617	(875)	45,007
Operating costs	5,339	1,778	23,926	16	(23,782)	7,277
Depreciation and amortization	236	92	129	1	(104)	354
Total operating expenses	45,718	6,992	24,055	634	(24,761)	52,638
Income (loss) from operations	937	257	1,067	(520)	—	1,741
Interest expense	—	—	—	—	189	189
Income (loss) before income taxes	$ 937	$ 257	$ 1,067	$ (520)	$ (189)	$ 1,552

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 75% for 2016, compared to 73% for 2015, and 73% for 2014.

Premiums revenue for our Retail segment for 2016 includes a reduction of $583 million associated with the write-off of commercial risk corridor receivables as discussed more fully in Note 7.

Benefits expense for Other Businesses for 2016 includes $505 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)		
2015						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 29,526	$ —	$ —	$ —	$ —	$ 29,526
Group Medicare Advantage	5,588	—	—	—	—	5,588
Medicare stand-alone PDP	3,846	—	—	—	—	3,846
Total Medicare	38,960	—	—	—	—	38,960
Fully-insured	4,243	5,493	—	—	—	9,736
Specialty	261	1,055	—	—	—	1,316
Medicaid and other	2,341	21	—	35	—	2,397
Total premiums	45,805	6,569	—	35	—	52,409
Services revenue:						
Provider	—	40	655	—	—	695
ASO and other	9	658	—	14	—	681
Pharmacy	—	—	30	—	—	30
Total services revenue	9	698	685	14	—	1,406
Total revenues—external customers	45,814	7,267	685	49	—	53,815
Intersegment revenues						
Services	—	93	17,997	—	(18,090)	—
Products	—	—	4,923	—	(4,923)	—
Total intersegment revenues	—	93	22,920	—	(23,013)	—
Investment income	134	26	—	76	238	474
Total revenues	45,948	7,386	23,605	125	(22,775)	54,289
Operating expenses:						
Benefits	39,708	5,266	—	87	(792)	44,269
Operating costs	5,118	1,769	22,481	14	(22,064)	7,318
Depreciation and amortization	192	93	143	—	(73)	355
Total operating expenses	45,018	7,128	22,624	101	(22,929)	51,942
Income from operations	930	258	981	24	154	2,347
Gain on sale of business	—	—	—	—	270	270
Interest expense	—	—	—	—	186	186
Income before income taxes	$ 930	$ 258	$ 981	$ 24	$ 238	$ 2,431

Benefits expense for the Retail segment for 2015 includes $176 million for a provision for probable future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year as discussed more fully in Note 7.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)		
2014						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 25,782	$ —	$ —	$ —	$ —	$ 25,782
Group Medicare Advantage	5,490	—	—	—	—	5,490
Medicare stand-alone PDP	3,404	—	—	—	—	3,404
Total Medicare	34,676	—	—	—	—	34,676
Fully-insured	3,265	5,339	—	—	—	8,604
Specialty	256	1,098	—	—	—	1,354
Medicaid and other	1,255	19	—	51	—	1,325
Total premiums	39,452	6,456	—	51	—	45,959
Services revenue:						
Provider	—	23	1,254	—	—	1,277
ASO and other	39	740	—	9	—	788
Pharmacy	—	—	99	—	—	99
Total services revenue	39	763	1,353	9	—	2,164
Total revenues—external customers	39,491	7,219	1,353	60	—	48,123
Intersegment revenues						
Services	—	78	15,098	—	(15,176)	—
Products	—	—	3,749	—	(3,749)	—
Total intersegment revenues	—	78	18,847	—	(18,925)	—
Investment income	97	23	—	60	197	377
Total revenues	39,588	7,320	20,200	120	(18,728)	48,500
Operating expenses:						
Benefits	33,508	5,130	—	102	(574)	38,166
Operating costs	4,576	1,936	19,307	17	(18,197)	7,639
Depreciation and amortization	165	103	155	—	(90)	333
Total operating expenses	38,249	7,169	19,462	119	(18,861)	46,138
Income from operations	1,339	151	738	1	133	2,362
Interest expense	—	—	—	—	192	192
Income (loss) before income taxes	$ 1,339	$ 151	$ 738	$ 1	$ (59)	$ 2,170

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for approximately 1% of our consolidated premiums and services revenue for the year ended December 31, 2016. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). As discussed in Note 2, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model because premiums received in the current year are intended to pay anticipated benefits in that year.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2016 and 2015.

	2016		2015	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 119	$ —	$ 135	$ —
Trade accounts payable and accrued expenses	—	(62)	—	(64)
Long-term liabilities	—	(2,834)	—	(2,151)
Total asset (liability)	$ 119	$ (2,896)	$ 135	$ (2,215)

In addition, future policy benefits payable include amounts of $201 million at December 31, 2016 and $205 million at December 31, 2015 which are subject to 100% coinsurance agreements as more fully described in Note 19.

In 2016, we recorded a net increase in benefits expense of $439 million, including a net charge of $505 million associated with our closed block of long-term care insurance policies discussed further below, partially offset by the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law. In 2015, we recorded a net reduction in benefits expense of $80 million associated with future policy benefits primarily due to the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law. Benefits expense associated with future policy benefits payable was $32 million in 2014. Amortization of deferred acquisition costs included in operating costs was $67 million in 2016, $63 million in 2015, and $39 million in 2014. The higher amortization in 2015 and 2016 primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

Future policy benefits payable include $2.2 billion at December 31, 2016 and $1.5 billion at December 31, 2015 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current

yields. There was a $77 million additional liability at December 31, 2016 and no additional liability at December 31, 2015. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual premium rate increase, interest, morbidity, mortality, persistency, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, material future adjustments to reserves could be required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets.

Deferred acquisition costs included $16 million and $26 million associated with our individual commercial medical policies at December 31, 2016 and December 31, 2015, respectively. Future policy benefits payable associated with our individual commercial medical policies were $86 million at December 31, 2016 and $180 million at December 31, 2015. The decline in deferred acquisition costs and future policy benefits payable primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, and annuities in run-off status, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Excluding reinsurance associated with the Health Care Reform Law discussed in Note 2, reinsurance recoverables, included in other current and long-term assets, were $822 million at December 31, 2016 and $668 million at December 31, 2015. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 34% at December 31, 2016 and approximately 43% at December 31, 2015. Premiums ceded were $842 million in 2016, $821 million in 2015 and $357

million in 2014. Benefits ceded were $767 million in 2016, $666 million in 2015, and $272 million in 2014. Ceded premium and benefits reflect a July 1, 2014 amendment ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2016 presented below:

Reinsurer	Total Recoverable	A.M. Best Rating at December 31, 2016
	(in millions)	
Munich American Reassurance Company	$ 248	A+ (superior)
Protective Life Insurance Company	182	A+ (superior)
Employers Reassurance Corporation	130	A- (excellent)
General Re Life Corporation	129	A++ (superior)
All others	133	A+ to A- (superior to excellent)
	$ 822	

The all other category represents 18 reinsurers with individual balances less than $76 million. Three of these reinsurers with recoverables of $93 million are subject to trust or funds withheld accounts, requiring amounts at least equal to the total recoverable from each of these reinsurers.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.:

In our opinion, the consolidated balance sheets and the related consolidated statements of income, of comprehensive income, of stockholders' equity and of cash flows present fairly, in all material respects, the financial position of Humana Inc. and its subsidiaries at December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2016 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the index appearing under Item 15(a)(2) present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky
February 17, 2017

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2016 and 2015 follows:

	2016			
	First	Second	Third	Fourth (2)(3)
	(in millions, except per share results)			
Total revenues	$ 13,800	$ 14,007	$ 13,694	$ 12,878
Income (loss) before income taxes	500	636	902	(486)
Net income (loss)	254	311	450	(401)
Basic earnings (loss) per common share	$ 1.70	$ 2.08	$ 3.01	$ (2.68)
Diluted earnings (loss) per common share (1)	$ 1.68	$ 2.06	$ 2.98	$ (2.68)

	2015			
	First	Second	Third	Fourth (4)
	(in millions, except per share results)			
Total revenues	$ 13,833	$ 13,732	$ 13,363	$ 13,361
Income before income taxes	744	793	648	246
Net income	430	431	314	101
Basic earnings per common share	$ 2.86	$ 2.88	$ 2.11	$ 0.68
Diluted earnings per common share (1)	$ 2.82	$ 2.85	$ 2.09	$ 0.67

(1) The calculation of diluted earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year. In addition, for 2016, the sum of quarterly amounts does not equal full year results due to the anti-dilutive impact of a loss in the fourth quarter. The loss position in the fourth quarter required the use of basic weighted-average common shares outstanding in the calculation of diluted loss per share.

(2) The fourth quarter of 2016 includes an expense of $505 million ($318 million after tax, or 2.11 per diluted common share) for reserve strengthening associated with our closed block of long-term care insurance policies.

(3) Total revenue for 2016 includes a reduction of $583 million ($367 million after-tax, or $2.43 per diluted common share) in premiums associated with the write-off of risk corridor receivables.

(4) The fourth quarter of 2015 includes an expense of $176 million ($112 million after tax, or $0.74 per diluted common share) for a premium deficiency reserve associated with our individual commercial medical policies compliant with the Health Care Reform Law associated with the 2016 coverage year.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2016, we as the principal executive officer and the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2016. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2016, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2016 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 140.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Bruce D. Broussard
President and Chief Executive Officer (Principal Executive Officer)

Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Cynthia H. Zipperle
Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2017, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	54	President and Chief Executive Officer, Director	12/11	(1)
James E. Murray	63	Executive Vice President and Chief Operating Officer	08/90	(2)
Roy A. Beveridge, M.D.	59	Senior Vice President and Chief Medical Officer	06/13	(3)
Jody L. Bilney	55	Senior Vice President and Chief Consumer Officer	04/13	(4)
Christopher H. Hunter	48	Senior Vice President and Chief Strategy Officer	01/14	(5)
Timothy S. Huval	50	Senior Vice President and Chief Human Resources Officer	12/12	(6)
Brian A. Kane	44	Senior Vice President and Chief Financial Officer	06/14	(7)
Christopher Kay	51	Senior Vice President and Chief Innovation Officer	03/14	(8)
Brian P. LeClaire	56	Senior Vice President and Chief Information Officer	08/11	(9)
Heidi S. Margulis	63	Senior Vice President – Corporate Affairs	12/95	(10)
Christopher M. Todoroff	54	Senior Vice President and General Counsel	08/08	(11)
Cynthia H. Zipperle	54	Vice President, Chief Accounting Officer and Controller	12/14	(12)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Mr. Murray currently serves as Executive Vice President and Chief Operating Officer, having held this position since December 2011. Mr. Murray has held the position of Chief Operating Officer since February 2006, and was the Chief Operating Officer – Market and Business Segment Operations from September 2002 to February 2006. Mr. Murray joined the Company in December 1989. On February 8, 2017, the Company announced that Mr. Murray intends to retire from the position of Executive Vice President and Chief Operating Office effective March 31, 2017.

(3) Dr. Beveridge currently serves as Senior Vice President and Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(4) Ms. Bilney currently serves as Senior Vice President and Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(5) Mr. Hunter currently serves as Senior Vice President and Chief Strategy Officer, having held this position since joining the Company in January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(6) Mr. Huval currently serves as Senior Vice President and Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(7) Mr. Kane currently serves as Senior Vice President and Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(8) Mr. Kay currently serves of Senior Vice President and Chief Innovation Officer, having been elected to this position in March 2014. Prior to joining the Company, Mr. Kay was most recently Managing Director and CEO of Citi Ventures, Citigroup's global corporate venturing arm. Prior to joining Citi in 2007, Mr. Kay held several leadership positions at Target over a 12-year period.

(9) Mr. LeClaire currently serves as Senior Vice President and Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(10) Ms. Margulis currently serves as Senior Vice President – Corporate Affairs, having held this position since January 2000. Ms. Margulis joined the Company in November 1985.

(11) Mr. Todoroff currently serves as Senior Vice President and General Counsel, having held this position since August 2008. Prior to joining the Company, Mr. Todoroff served as Vice President, Senior Corporate Counsel and Corporate Secretary for Aetna Inc. from 2006 through July 2008. Mr. Todoroff joined Aetna's Legal Department in 1995 and held various positions of increasing responsibility.

(12) Mrs. Zipperle currently serves as Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com. Any waiver of the application of the Humana Inc. Principles of Business Ethics to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the captions "Corporate Governance – Organization & Compensation Committee – Compensation Committee Interlocks and Insider Participation," "Director Compensation," "Compensation Discussion and Analysis," "Organization & Compensation Committee Report," and "Executive Compensation" of such Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2016 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	1,021,590	$ 143.043	7,052,923	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	1,021,590	$ 143.043	7,052,923	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.

(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) Of the number listed above, 3,079,879 can be issued as restricted stock at December 31, 2016 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions "Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Security Ownership of Directors and Executive Officers" in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Audit Committee Report" of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Financial Information
Schedule II	Valuation and Qualifying Accounts

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

2.1 Agreement and Plan of Merger, dated as of July 2, 2015 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 2.1 to Humana Inc.'s Current Report on Form 8-K filed on July 7, 2015).

2.2 Letter Agreement, dated as of December 21, 2016, between Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on December 22, 2016).

2.3 Termination letter dated as of February 14, 2017, by and among Humana Inc., Aetna Inc., Echo Merger Sub, Inc. and Echo Merger Sub LLC (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on February 14, 2017).

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) By-Laws of Humana Inc., as amended on January 4, 2007 (incorporated herein by reference to Exhibit 3 to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2006).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(f) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006).

(g) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(h) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(i) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(j) Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(k) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(l) Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

10(a)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(b)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(c)* Humana Inc. Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 27, 2006).

(d)* Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 1, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).

(e)* Form of Change of Control Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).

(f)* Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999).

(g)* The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(h)* Severance policy as amended and restated on October 23, 2007 (incorporated herein by reference to Exhibit 10(r) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2007).

(i)* Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).

(j)* Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 17, 2011).

(k)* Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994).

(l)* Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).

(m)* Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).

(n)* ** Form of Company's Restricted Stock Unit Agreement with Time/Performance Vesting and Agreement not to Compete or Solicit, under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(t) to Humana Inc.'s Annual Report on Form 10-K/A filed on January 30, 2014).

(o)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(p)* Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.

(q)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(r) Five-Year Credit Agreement, dated as of July 9, 2013 (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on July 10, 2013).

(s) Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(t) Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(u) Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(v) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(w) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(x) Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(y) Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005).

(z)* Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).

(aa)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(oo) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(bb)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(pp) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(cc)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(dd)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(ee)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).
(ff)**	Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as March 3, 2011 (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(gg)*	Form of Amendment to Change of Control Agreement between Humana Inc. and various executive officers (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).
(hh)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 6, 2014).
(ii)	Master Confirmation by and between Humana Inc. and Goldman, Sachs & Co., dated November 7, 2014 (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on November 10, 2014).
(jj)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(kk)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
12 †	Computation of ratio of earnings to fixed charges.
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.
101	The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2016 and 2015; (ii) the

Consolidated Statements of Income for the years ended December 31, 2016, 2015 and 2014; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2016, 2015 and 2014; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2016, 2015, and 2014; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2016, 2015 and 2014; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(q) and 10(z) through and including 10(ee),10(gg),10(jj) and 10(ii) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2016	2015
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,710	$ 1,389
Investment securities	300	256
Receivable from operating subsidiaries	1,136	1,124
Other current assets	122	224
Total current assets	3,268	2,993
Property and equipment, net	1,086	1,011
Investments in subsidiaries	15,276	14,276
Other long-term assets	374	410
Total assets	$ 20,004	$ 18,690
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 4,107	$ 3,322
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	38	38
Short-term borrowings	300	299
Other current liabilities	708	572
Total current liabilities	5,181	4,259
Long-term debt	3,792	3,794
Notes payable to operating subsidiaries	9	9
Other long-term liabilities	337	282
Total liabilities	9,319	8,344
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,495,007 shares issued at December 31, 2016 and 198,372,059 shares issued at December 31, 2015	33	33
Capital in excess of par value	2,562	2,530
Retained earnings	11,454	11,017
Accumulated other comprehensive income	(66)	58
Treasury stock, at cost, 49,189,811 shares at December 31, 2016 and 50,084,043 shares at December 31, 2015	(3,298)	(3,292)
Total stockholders' equity	10,685	10,346
Total liabilities and stockholders' equity	$ 20,004	$ 18,690

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 1,683	$ 1,469	$ 1,509
Investment and other income, net	42	5	4
	1,725	1,474	1,513
Expenses:			
Operating costs	1,623	1,370	1,434
Depreciation	302	252	212
Interest	189	186	192
	2,114	1,808	1,838
Loss before gain on sale of business, income taxes and equity in net earnings of subsidiaries	(389)	(334)	(325)
Gain on sale of business	—	270	—
Loss before income taxes and equity in net earnings of subsidiaries	(389)	(64)	(325)
Benefit for income taxes	(107)	(70)	(81)
Income (loss) before equity in net earnings of subsidiaries	(282)	6	(244)
Equity in net earnings of subsidiaries	896	1,270	1,391
Net income	$ 614	$ 1,276	$ 1,147

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Net income	$ 614	$ 1,276	$ 1,147
Other comprehensive (loss) income:			
Change in gross unrealized investment gains/losses	(101)	(114)	122
Effect of income taxes	38	42	(44)
Total change in unrealized investment gains/losses, net of tax	(63)	(72)	78
Reclassification adjustment for net realized gains included in investment income	(96)	(146)	(20)
Effect of income taxes	35	53	7
Total reclassification adjustment, net of tax	(61)	(93)	(13)
Other comprehensive (loss) income, net of tax	(124)	(165)	65
Comprehensive income	$ 490	$ 1,111	$ 1,212

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Net cash provided by operating activities	$ 1,848	$ 953	$ 1,499
Cash flows from investing activities:			
Proceeds from sale of business	—	1,055	—
Capital contributions to operating subsidiaries	(895)	(833)	(442)
Purchases of investment securities	(151)	(507)	(629)
Proceeds from sale of investment securities	25	18	606
Maturities of investment securities	143	108	149
Purchases of property and equipment, net	(382)	(378)	(380)
Net cash used in investing activities	(1,260)	(537)	(696)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	—	—	1,733
Proceeds from issuance of commercial paper, net	(2)	298	—
Repayment of long-term debt	—	—	(500)
Change in book overdraft	5	(16)	(5)
Common stock repurchases	(104)	(385)	(872)
Dividends paid	(177)	(172)	(172)
Tax benefit from stock-based compensation	—	15	12
Proceeds from stock option exercises and other	11	22	51
Net cash (used in) provided by financing activities	(267)	(238)	247
Increase in cash and cash equivalents	321	178	1,050
Cash and cash equivalents at beginning of year	1,389	1,211	161
Cash and cash equivalents at end of year	$ 1,710	$ 1,389	$ 1,211

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

Related Party

Refer to Note 2 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of our related party transactions. A related party note receivable is included with other long-term assets in our condensed balance sheet at December 31, 2016 and December 31, 2015 in the amount of $314 million and $284 million, respectively. The related interest income of $30 million for 2016 is included in investment and other income in our condensed statement of income.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $763 million in 2016, $493 million in 2015, and $927 million in 2014.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by our parent company in the event of insolvency for: (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent has also guaranteed the obligations of our military services subsidiaries.

Notes Receivables from Operating Subsidiaries

We funded certain subsidiaries with surplus note agreements. These notes are generally non-interest bearing and may not be entered into or repaid without the prior approval of the applicable Departments of Insurance or other state regulatory authorities.

Notes Payable to Operating Subsidiaries

We borrowed funds from certain subsidiaries with notes generally collateralized by real estate. These notes, which have various payment and maturity terms, bear interest ranging from 1.93% to 6.65% and are payable in 2017 and 2019. We recorded interest expense of $1 million related to these notes for each of the years ended December 31, 2016, 2015 and 2014.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS—(Continued)

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.7 billion and $6.6 billion as of December 31, 2016 and 2015, respectively, which exceeded aggregate minimum regulatory requirements of $4.8 billion and $4.6 billion, respectively. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2017 is approximately $850 million in the aggregate. This compares to dividends that were paid to our parent company in 2016 of approximately $763 million. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Our parent company funded a subsidiary capital contribution of approximately $535 million in the first quarter of 2017 for reserve strengthening associated with our closed block of long-term care insurance policies discussed further in Note 18 of the notes to consolidated financial statements in this Annual Report on Form 10-K.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc. During 2016, 2015 and 2014, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2016, 2015, and 2014
(in millions)

	Balance at Beginning of Period	Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2016	$ 101	$ —	$ 39	$ 19	$ (41)	$ 118
2015	137	(39)	61	(7)	(51)	101
2014	118	—	32	28	(41)	137
Deferred tax asset valuation allowance:						
2016	(42)	—	(7)	—	—	(49)
2015	(48)	—	6	—	—	(42)
2014	(28)	—	(20)	—	—	(48)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE

Brian A. Kane

Senior Vice President and Chief Financial Officer
(Principal Financial Officer)

Date: February 17, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	February 17, 2017
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)	February 17, 2017
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 17, 2017
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 17, 2017
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 17, 2017
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 17, 2017
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 17, 2017
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 17, 2017
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 17, 2017
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 17, 2017
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 17, 2017
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 17, 2017

Exhibit 12

Humana Inc.
Computation of Ratio of Earnings to Fixed Charges

	For the twelve months ended December 31,				
	2016	**2015**	**2014**	**2013**	**2012**
	(Dollars in millions)				
Income before income taxes	$ 1,552	$ 2,431	$ 2,170	$ 1,921	$ 1,911
Fixed charges	249	253	267	216	178
Total earnings	$ 1,801	$ 2,684	$ 2,437	$ 2,137	$ 2,089
Interest charged to expense	$ 189	$ 186	$ 192	$ 140	$ 105
One-third of rent expense	60	67	75	76	73
Total fixed charges	$ 249	$ 253	$ 267	$ 216	$ 178
Ratio of earnings to fixed charges (1)(2)	7.2x	10.6x	9.1x	9.9x	11.7x

Notes
(1) For the purposes of determining the ratio of earnings to fixed charges, earnings consist of income before income taxes and fixed charges. Fixed charges include gross interest expense, amortization of deferred financing expenses and an amount equivalent to interest included in rental charges. One-third of rental expense represents a reasonable approximation of the interest amount.
(2) There are no shares of preferred stock outstanding.

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARIZONA
1. SeniorBridge Family Companies (AZ), Inc.

ARKANSAS
1. Humana Regional Health Plan, Inc.

CALIFORNIA
1. HRI Humana of California Inc.
2. Humana Health Plan of California, Inc.
3. SeniorBridge Family Companies (CA), Inc.

CONNECTICUT
1. SeniorBridge Family Companies (CT), Inc.

DELAWARE
1. American Tax Credit Corporate Georgia Fund III, L.L.C.
2. Availity, L.L.C.
3. B-Cycle, LLC
4. CompBenefits Corporation
5. CompBenefits Direct, Inc.
6. DefenseWeb Technologies, Inc.
7. Emphesys, Inc.
8. Go365, LLC
9. Health Value Management, Inc.
10. HUM Provider Holdings, LLC
11. Humana at Home, Inc.
12. Humana Government Business, Inc.
13. Humana Inc.
14. Humana Innovation Enterprises, Inc.
15. Humana Pharmacy, Inc.
16. Humana Veterans Healthcare Services, Inc.
17. Humana WellWorks LLC
18. HumanaDental, Inc.
19. Primary Care Holdings, Inc.
20. Transcend Insights, Inc.
21. Transcend Population Health Management, LLC

FLORIDA
1. 154th Street Medical Plaza, Inc.
2. 1st Choice Home Health Care, LLC
3. 54th Street Medical Plaza, Inc.
4. American Eldercare of North Florida, LLC
5. American Eldercare, Inc.
6. CAC Medical Center Holdings, Inc.
7. CAC-Florida Medical Centers, LLC
8. Care Partners Home Care, LLC
9. CarePlus Health Plans, Inc.
10. CompBenefits Company
11. Complex Clinical Management, Inc.
12. Continucare Corporation
13. Continucare MDHC, LLC
14. Continucare Medical Management, Inc.
15. Continucare MSO, Inc.

16. DataLink Solutions, Inc.
17. HUM-e-FL, Inc.
18. Humana At Home 1, Inc.
19. Humana Dental Company
20. Humana Health Insurance Company of Florida, Inc.
21. Humana Medical Plan, Inc.
22. METCARE of Florida, Inc.
23. Metropolitan Health Networks, Inc.
24. Naples Health Care Specialists, LLC
25. Nursing Solutions, LLC
26. Partners in Integrated Care, Inc.
27. SeniorBridge Family Companies (FL), Inc.
28. SeniorBridge-Florida, LLC

GEORGIA
1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS
1. CompBenefits Dental, Inc.
2. Comprehensive Health Insights, Inc.
3. Dental Care Plus Management, Corp.
4. Humana Benefit Plan of Illinois, Inc.
5. Humana Dental Concern, Ltd.
6. SeniorBridge Family Companies (IL), Inc.

INDIANA
1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY
1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. CHA Service Company
4. Humana Active Outlook, Inc.
5. Humana Health Plan, Inc.
6. Humana Insurance Company of Kentucky
7. Humana MarketPOINT, Inc.
8. Humana Pharmacy Solutions, Inc.
9. Humco, Inc.
10. Preservation on Main, Inc.
11. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MARYLAND
1. SeniorBridge Family Companies (MD), Inc.

MASSACHUSETTS
1. Humana at Home (MA), Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

MISSOURI
1. SeniorBridge Family Companies (MO), Inc.

NEW JERSEY
1. SeniorBridge Family Companies (NJ), Inc.

NEW YORK
1. Harris, Rothenberg International Inc.
2. Humana Health Company of New York, Inc.
3. Humana Insurance Company of New York
4. SeniorBridge Care Management, Inc.
5. SeniorBridge Family Companies (NY), Inc.

NORTH CAROLINA
1. SeniorBridge (NC), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.
2. Hummingbird Coaching Systems LLC
3. SeniorBridge Family Companies (OH), Inc.

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.
2. SeniorBridge Family Companies (PA), Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

SOUTH CAROLINA
1. Kanawha Insurance Company

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. Corphealth Provider Link, Inc.
3. DentiCare, Inc.
4. Emphesys Insurance Company
5. Humana At Home (Dallas), Inc.
6. Humana At Home (Houston), Inc.
7. Humana At Home (San Antonio), Inc.
8. Humana At Home (TLC), Inc.
9. Humana Behavioral Health, Inc.
10. Humana Health Plan of Texas, Inc.
11. ROHC, L.L.C.
12. Texas Dental Plans, Inc.

UTAH
1. Humana Medical Plan of Utah, Inc.

VERMONT
1. Managed Care Indemnity, Inc.

VIRGINIA
1. KMG America Corporation
2. SeniorBridge Family Companies (VA), Inc.

WASHINGTON

1. Arcadian Health Plan, Inc.

WISCONSIN

1. CareNetwork, Inc.
2. Humana Insurance Company
3. Humana Wisconsin Health Organization Insurance Corporation
4. HumanaDental Insurance Company
5. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and Form S-3 (No. 333-180023) of Humana Inc. of our report dated February 17, 2017 relating to the financial statements, financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

Louisville, Kentucky

February 17, 2017

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 17, 2017

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 17, 2017

Signature: /s/ BRIAN A. KANE

Brian A. Kane
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2016 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 17, 2017

/s/ BRIAN A. KANE

Brian A. Kane
Senior Vice President and Chief Financial Officer
(Principal Financial Officer)

February 17, 2017

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2017
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (502) 580-1000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of exchange on which registered**
Common stock, $0.16 2/3 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2017 was $34,733,751,307 calculated using the average price on June 30, 2017 of $240.77.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2018 was 137,684,326.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 19, 2018.

HUMANA INC.
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For the Year Ended December 31, 2017

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Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

As of December 31, 2017, we had approximately 14 million members in our medical benefit plans, as well as approximately 7 million members in our specialty products. During 2017, 79% of our total premiums and services revenue were derived from contracts with the federal government, including 15% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 609,600 members as of December 31, 2017.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2017 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2017 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as

Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. On February 14, 2017, we and Aetna agreed to mutually terminate the July 2, 2015 Agreement and Plan of Merger as more fully discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year industry wide commercial reinsurance fee. The Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform" in this 2017 Form 10-K.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur. We may be unable to adjust our product offerings, geographic footprint, or pricing during any given year such legislative changes occur in sufficient time to mitigate any adverse effects.

Business Segments

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require

the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2017:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 32,720	61.3%
Group Medicare Advantage	5,155	9.7%
Medicare stand-alone PDP	3,702	6.9%
Total Retail Medicare	41,577	77.9%
State-based Medicaid	2,571	4.8%
Medicare Supplement	478	0.9%
Total premiums	44,626	83.6%
Services	10	—%
Total premiums and services revenue	$ 44,636	83.6%

Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may

choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage, or MA, plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS.

At December 31, 2017, we provided health insurance coverage under CMS contracts to approximately 2,860,800 individual Medicare Advantage members, including approximately 609,600 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.8 billion, which represented approximately 23.8% of

our individual Medicare Advantage premiums revenue, or 14.6% of our consolidated premiums and services revenue for the year ended December 31, 2017.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2018, and all of our product offerings filed with CMS for 2018 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled "Medicare Part D." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2018, and all of our product offerings filed with CMS for 2018 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

State-based Medicaid Contracts

Our state-based contracts allow us to serve members enrolled in state-based Medicaid programs including Temporary Assistance to Needy Families, or TANF, Long-Term Support Services, or LTSS, and dual eligible demonstration programs. TANF is a state and federally funded program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term support services for our members who receive home and community or institution-based services for long-term care. Our contracts are generally for three to five year terms.

We have contracts to serve Medicaid eligible members in Florida and Kentucky under the TANF program, as well as contracts in Florida under the LTSS program. Our Kentucky Medicaid contract is subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and

Medicare costs. There were approximately 10.7 million dual eligible individuals in the United States in 2017, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and LTSS benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs.

We previously had an Integrated Care Program, or ICP, Medicaid contract in Illinois and a stand-alone dual eligible demonstration program in Virginia, both of which terminated on December 31, 2017. We continue to serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2017:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,462	10.2%
Specialty	1,310	2.5%
Total premiums	6,772	12.7%
Services	626	1.2%
Total premiums and services revenue	$ 7,398	13.9%
Intersegment services revenue	$ 20	n/a

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses.

Our administrative services only, or ASO, products are offered to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing substantially all of the cost of health benefits. However, more than half of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

Employers can customize their offerings with optional benefits such as dental, vision, life, and a portfolio of voluntary benefit products. We also offer optional benefits such as dental, vision life, and a portfolio of financial protection products to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. During 2017, we delivered services under the 5-year T3 South Region contract, which expired on December 31, 2017. On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The T2017 East contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2017:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 20,881	n/a
Provider services	1,593	n/a
Clinical care services	1,111	n/a
Total intersegment revenue	$ 23,585	
External services revenue:		
Pharmacy solutions	$ 80	0.2%
Provider services	77	0.1%
Clinical care services	181	0.3%
Total external services revenue	$ 338	0.6%

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through Humana Pharmacy, Inc., as well as research services.

Provider services

We operate full-service, multi-specialty medical centers, primarily in Florida, staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

We also operate Transcend, a Medical Services Organization, or MSO, that coordinates medical care for Medicare Advantage beneficiaries primarily in four states. Transcend provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Transcend collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions. Transcend represents a key component of our integrated care delivery model which we believe is scalable to new markets. In addition, we own a noncontrolling equity interest in MCCI Holdings, LLC, a privately held MSO headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas.

Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We believe that technology represents a significant opportunity in health care that positively impacts our members. Our Transcend Insights business focuses on population health and wellness capabilities across the sector and serves health care systems, physicians and care teams by leveraging actionable data to help improve patient care. We help care teams and patients transition from a reactive approach to care to one that proactively promotes health and long-term wellness. We have enhanced our health information technology capabilities enabling us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, that delivered occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home ®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2017, we have enrolled approximately 794,900 members with complex chronic conditions in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities. On December 19, 2017, we announced that we had entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division of Kindred Healthcare Inc., the nation's largest home health provider and second largest hospice operator.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs.

Our care management programs take full advantage of the population health, wellness and clinical applications offered by Transcend Insights and CareHub, our clinical management tool used by providers and care managers across the company to help our members achieve their best health, to offer various levels of support, matching the intensity of the support to the needs of members with ongoing health challenges through telephonic and onsite programs. These programs include Personal Nurse, chronic condition management, and case management as well as programs supporting maternity, cancer, neonatal intensive care unit, and transplant services.

Wellness

We offer wellness solutions including our Go365 wellness and loyalty rewards program, health coaching, employee assistance program, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Go365 program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual's needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

Our Individual Commercial Segment Products

Our individual health plans were marketed under the HumanaOne brand. We offered products both on and off of the public exchange. We offered products on exchanges where we could achieve an affordable cost of care, including HMO offerings and select networks in most markets. Our off-exchange products were primarily PPO and POS offerings, including plans issued prior to 2014 that were previously underwritten. Policies issued prior to the enactment of the Health Care Reform Law on March 23, 2010 were grandfathered policies. Grandfathered policies are exempt from most of the requirements of the Health Care Reform Law, including mandated benefits. However, our grandfathered plans included provisions that guaranteed renewal of coverage for as long as the plan is continued and the individual chooses to renew. Policies issued between March 23, 2010 and December 31, 2013 were required to conform to the Health Care Reform Law, including mandated benefits, upon renewal at various transition dates between 2016 and 2017 depending on the state.

We discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. We exited our remaining individual commercial medical business effective January 1, 2018 as more fully described in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Other Businesses

Other Businesses primarily includes our closed block of long-term care insurance policies described below. Total premiums and services revenue for our Other Businesses was $43 million, or 0.1% of consolidated premiums and services revenue for the year ended December 31, 2017.

We have a non-strategic closed block of approximately 29,800 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care insurance policies. For a detailed discussion of the definitive agreement refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31, 2017, by market and product:

	Retail Segment				Group and Specialty Segment							
					(in thousands)							
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Individual Commercial	Other Businesses	Total	Percent of Total
Florida	609.6	16.0	388.7	7.2	339.7	124.6	34.0	—	13.9	—	1,533.7	11.0%
Texas	225.0	189.6	331.9	8.7	—	201.3	23.8	—	5.2	—	985.5	7.0%
Kentucky	79.7	58.9	221.6	5.6	—	109.6	144.4	—	1.5	—	621.3	4.4%
California	64.8	0.4	490.5	19.5	—	—	—	—	—	—	575.2	4.1%
Ohio	119.3	20.3	194.9	47.7	—	50.6	51.2	—	1.2	—	485.2	3.5%
Illinois	95.1	22.0	190.9	4.5	12.8	59.9	76.0	—	6.4	—	467.6	3.3%
Georgia	113.9	1.8	135.9	10.5	—	163.7	27.6	—	1.7	—	455.1	3.3%
Missouri/Kansas	81.7	5.0	228.0	8.5	—	51.3	10.3	—	14.0	—	398.8	2.9%
Tennessee	146.1	3.9	119.2	4.4	—	42.3	10.1	—	57.6	—	383.6	2.7%
Louisiana	158.5	11.6	61.3	1.9	—	69.0	9.8	—	19.8	—	331.9	2.4%
North Carolina	142.4	0.4	184.5	0.7	—	—	—	—	—	—	328.0	2.3%
Wisconsin	59.9	10.9	121.7	5.7	—	84.2	30.1	—	—	—	312.5	2.2%
Virginia	116.6	2.6	158.3	8.6	7.6	—	—	—	—	—	293.7	2.1%
Indiana	93.0	7.0	146.6	8.2	—	20.1	12.3	—	—	—	287.2	2.1%
Michigan	49.1	12.5	150.3	3.0	—	3.7	0.4	—	4.9	—	223.9	1.6%
Pennsylvania	42.8	0.6	166.1	4.6	—	—	—	—	—	—	214.1	1.5%
Arizona	59.2	0.2	100.1	4.1	—	29.0	2.8	—	—	—	195.4	1.4%
South Carolina	88.5	0.4	89.0	5.0	—	—	—	—	—	—	182.9	1.3%
Military services	—	—	—	—	—	—	—	3,081.8	—	—	3,081.8	22.0%
Others	515.6	77.3	1,828.6	77.5	—	88.4	25.9	—	2.6	29.8	2,645.7	18.9%
Totals	2,860.8	441.4	5,308.1	235.9	360.1	1,097.7	458.7	3,081.8	128.8	29.8	14,003.1	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate for diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2017, approximately 1,102,100 members, or 7.9% of our medical membership, were covered under risk-based contracts, including 903,500 individual Medicare Advantage members, or 31.6% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 170,700 HMO members, including 155,500 individual Medicare Advantage members, or 17.2% of the 903,500 individual Medicare Advantage members covered under risk-based contracts at December 31, 2017, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.4 billion, or 3.2% of total benefits expense, for the year ended December 31, 2017. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or the Joint Commission on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee, composed of a peer group of providers, reviews the applications of providers being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care, and URAC. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Additionally, all products sold on the federal and state marketplaces are required to be accredited. Certain commercial businesses, like those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in most of our commercial, Medicare and Medicaid HMO/POS markets with enough history and membership, and for many of our PPO markets.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2017, we employed approximately 1,600 sales representatives, as well as approximately 1,300 telemarketing representatives who assisted in the marketing of Medicare in our Retail segment, individual commercial health insurance in our Individual Commercial segment, and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs

and expectations of their employees or members. In addition, we offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange where employees can shop for a health plan and other benefits based on what the employer has selected as options. We use licensed independent brokers, independent agents, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our individual commercial health insurance and specialty products.

Underwriting

Since 2014, the Health Care Reform Law requires all individual and certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, newly issued individual and certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2017 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2017 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service. Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

Employees

As of December 31, 2017, we had approximately 45,900 employees and approximately 2,000 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to Certain Proposed Transactions

Certain proposed transactions, including the divestiture of our subsidiary, KMG, and the acquisition of a minority interest in Kindred Healthcare, Inc.'s Kindred at Home division, are subject to various closing conditions, including various regulatory approvals and customary closing conditions, as well as other uncertainties, and there can be no assurances as to whether and when it may be completed.

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies that serves approximately 29,800 policyholders. On December 19, 2017, we announced that we had entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home division of Kindred Healthcare, Inc. Consummation of each of these transactions involves certain risks, including, among other things, the timing to consummate the transaction, the risk that a condition to closing of the transaction may not be satisfied, the risk that required regulatory approvals for the transaction are not obtained, are delayed or are subject to conditions that are not anticipated, the risk that we may not recognize all or a portion of the expected benefits from either or both transactions, including tax benefits and expected synergies, and the risk of indemnification exposure under the contractual agreements to effect the transactions.

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. We continually review these estimates, however these estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Any reserve, including a premium deficiency reserve, may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;

- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from the Health Care Reform Law.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

In addition, we also estimate costs associated with long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental insurance policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. Our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. However, to the extent premium rate increases or loss experience vary from the assumptions we have locked in, additional future adjustments to reserves could be required.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, any costs associated with exiting products, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, participation in health insurance exchanges, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee), and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable, or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

The policies and decisions of the federal and state governments regarding the Medicare, military and Medicaid programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives and our state-based contracts strategy, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products. In addition, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model and our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 78% of our total premiums and services revenue for the year ended December 31, 2017 generated from our Medicare products, including 15% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

Additionally, our strategy includes the growth of our commercial products, introduction of new products and benefit designs, including Go365 and other wellness products, growth of our specialty products such as dental, vision and other supplemental products, the adoption of new technologies, development of adjacent businesses, and the integration of acquired businesses and contracts.

The achievement of Star ratings of 4-Star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause

shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our associates' or members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment and employment discrimination-related suits, employee benefit claims, stockholder suits and other securities laws claims, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts or provider contract disputes relating to rate adjustments resulting from the Balance Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration");
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;
- claims relating to dispensing of drugs associated with our in-house mail-order pharmacy; and

- professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought.

While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 84% of our total premiums and services revenue for the year ended December 31, 2017. These programs involve various risks, as described further below.

- At December 31, 2017, under our contracts with CMS we provided health insurance coverage to approximately 609,600 individual Medicare Advantage members in Florida. These contracts accounted for approximately 15% of our total premiums and services revenue for the year ended December 31, 2017. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- Our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2017, primarily consisted of the T3 TRICARE South Region contract. The 5-year T3 South Region contract expired on December 31, 2017. On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government

does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.

- CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

  CMS is continuing to perform audits of various companies’ selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

  In 2012, CMS released a “Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits.” The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample will be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of Medicare FFS (we refer to the process of accounting for errors in FFS claims as the "FFS Adjuster"). This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans’ payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

  The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract

year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013 in which two, five and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, these ordinary course reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $279 million and $150 million at December 31, 2017 and 2016, respectively.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the applicable year.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 could have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with a non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). Financing for these reforms come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to

repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

For additional information, please refer to the section entitled, "Health Care Reform" in "Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing in this annual report.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, including reductions in Medicare Advantage payment rates, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

In addition to the Health Care Reform Law, the health care industry in general and health insurance are subject to substantial federal and state government regulation:

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act and HIPAA mandate individual notification in the event of a breach of unsecured, individually identifiable health information, provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business

associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires HHS to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure

our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. The divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. There can be no assurance that we will be able to complete any such divestitures on terms favorable to us.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected.

We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The U.S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it

has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii)

request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2017:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	147	—	68	226
Texas	—	19	2	15	36
Kentucky	2	1	11	10	24
Arizona	—	12	—	6	18
Louisiana	—	5	—	11	16
Virginia	—	9	—	7	16
California	—	—	2	13	15
South Carolina	—	6	4	5	15
Illinois	—	5	—	8	13
New York	—	—	—	13	13
Ohio	—	1	—	11	12
Indiana	—	4	—	7	11
Nevada	—	7	—	4	11
Puerto Rico	—	—	—	11	11
Tennessee	—	—	—	8	8
Colorado	—	5	—	3	8
Georgia	—	5	—	3	8
New Jersey	—	—	—	8	8
Michigan	—	5	—	3	8
Washington	—	4	—	3	7
North Carolina	—	2	—	5	7
Others	—	7	1	37	45
Total	13	244	20	259	536

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of the medical centers included in the table above, approximately 68 of these facilities are leased or subleased to our contracted providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2017 and 2016:

	High	Low
Year Ended December 31, 2017		
First quarter	$ 219.25	$ 195.24
Second quarter	$ 240.62	$ 209.77
Third quarter	$ 258.75	$ 230.77
Fourth quarter	$ 260.86	$ 233.28
Year Ended December 31, 2016		
First quarter	$ 186.91	$ 156.96
Second quarter	$ 190.07	$ 165.23
Third quarter	$ 180.86	$ 153.38
Fourth quarter	$ 216.76	$ 165.31

Holders of our Capital Stock

As of January 31, 2018, there were approximately 2,500 holders of record of our common stock and approximately 94,900 beneficial holders of our common stock.

Dividends

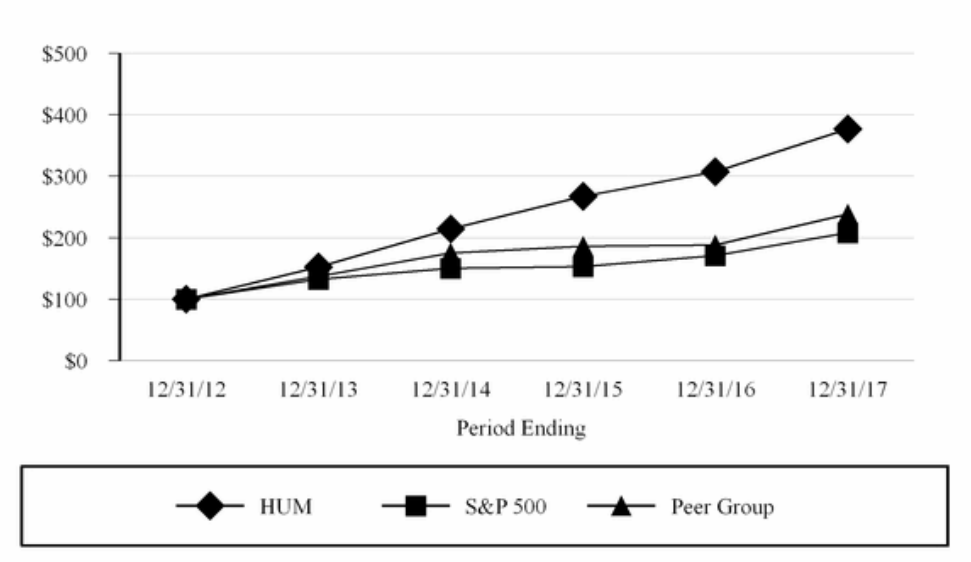
The following table provides details of dividend payments, excluding dividend equivalent rights, in 2016 and 2017, under our Board approved quarterly cash dividend policy:

Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2016 payments			
12/30/2015	1/29/2016	$0.29	$43
3/31/2016	4/29/2016	$0.29	$43
6/30/2016	7/29/2016	$0.29	$43
10/13/2016	10/28/2016	$0.29	$43
2017 payments			
1/12/2017	1/27/2017	$0.29	$43
3/31/2017	4/28/2017	$0.40	$58
6/30/2017	7/31/2017	$0.40	$58
9/29/2017	10/27/2017	$0.40	$57

On November 2, 2017, the Board declared a cash dividend of $0.40 per share that was paid on January 26, 2018 to stockholders of record on December 29, 2017, for an aggregate amount of $55 million.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2017. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2012, and that dividends were reinvested when paid.



	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017
HUM	$ 100	$ 152	$ 214	$ 267	$ 307	$ 377
S&P 500	$ 100	$ 132	$ 150	$ 153	$ 171	$ 208
Peer Group	$ 100	$ 137	$ 175	$ 186	$ 188	$ 238

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2017 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2)
October 2017	916,505	$ 244.44	916,505	$ 286,200,345
November 2017	846,752	244.54	846,752	79,136,387
December 2017	3,595,536	244.51	3,595,536	2,200,000,000
Total	5,358,793	$ 244.50	5,358,793	

(1) On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. We repurchased shares under an accelerated stock repurchase agreement and in the open market, utilizing the $2.25 billion authorization prior to expiration.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions, including pursuant to accelerated share repurchase agreements with investment banks, subject to certain regulatory restrictions on volume, pricing, and timing. On December 22, 2017, we announced that we had entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflects the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Our remaining repurchase authorization was approximately $2.0 billion as of February 16, 2018, excluding the $200 million pending final settlement of our December 22, 2017 ASR.

(2) Excludes 0.14 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

	2017	2016 (a)	2015 (b)	2014	2013 (c)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 52,380	$ 53,021	$ 52,409	$ 45,959	$ 38,829
Services	982	969	1,406	2,164	2,109
Investment income	405	389	474	377	375
Total revenues	53,767	54,379	54,289	48,500	41,313
Operating expenses:					
Benefits	43,496	45,007	44,269	38,166	32,564
Operating costs	6,567	7,173	7,295	7,639	6,355
Merger termination fee and related costs, net	(936)	104	23	—	—
Depreciation and amortization	378	354	355	333	333
Total operating expenses	49,505	52,638	51,942	46,138	39,252
Income from operations	4,262	1,741	2,347	2,362	2,061
Gain on sale of business	—	—	270	—	—
Interest expense	242	189	186	192	140
Income before income taxes	4,020	1,552	2,431	2,170	1,921
Provision for income taxes	1,572	938	1,155	1,023	690
Net income	$ 2,448	$ 614	$ 1,276	$ 1,147	$ 1,231
Basic earnings per common share	$ 16.94	$ 4.11	$ 8.54	$ 7.44	$ 7.81
Diluted earnings per common share	$ 16.81	$ 4.07	$ 8.44	$ 7.36	$ 7.73
Dividends declared per common share	$ 1.60	$ 1.16	$ 1.15	$ 1.11	$ 1.07
Financial Position:					
Cash and investments	$ 16,344	$ 13,675	$ 11,681	$ 11,482	$ 10,938
Total assets	27,178	25,396	24,678	23,497	20,719
Benefits payable	4,668	4,563	4,976	4,475	3,893
Debt	4,920	4,092	4,093	3,795	2,584
Stockholders' equity	9,842	10,685	10,346	9,646	9,316
Cash flows from operations	$ 4,051	$ 1,936	$ 868	$ 1,618	$ 1,716
Key Financial Indicators:					
Benefit ratio	83.0%	84.9%	84.5%	83.0%	83.9%
Operating cost ratio	12.3%	13.3%	13.6%	15.9%	15.5%
Membership by Segment:					
Retail segment:					
Medical membership	9,206,300	8,751,300	8,327,700	7,360,300	5,953,900
Group and Specialty segment:					
Medical membership	4,638,200	4,793,300	4,963,400	5,430,200	5,501,600
Specialty membership	6,986,000	6,961,200	7,221,800	7,668,500	7,823,300
Individual commercial segment:					
Medical membership	128,800	654,800	899,100	1,016,200	505,400
Other Businesses:					
Medical membership	29,800	30,800	32,600	35,000	23,400
Consolidated:					
Total medical membership	14,003,100	14,230,200	14,222,800	13,841,700	11,984,300
Total specialty membership	6,986,000	6,961,200	7,221,800	7,668,500	7,823,300

(a) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

(b) Includes a gain on the sale of Concentra Inc., net of transaction costs, of $270 million ($238 million after tax, or $1.57 per diluted common share). Also includes benefits expense of $176 million ($112 million after tax, or 0.74 per diluted common share) for a provision for probable

future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year.

(c) Includes benefits expense of $243 million ($154 million after tax, or $0.99 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, excluding depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. On February 16, 2017, under the terms of the Merger Agreement, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned Merger termination fee and related costs, net. Prior period Merger related transaction costs, previously included in operating costs, have been reclassified to conform to the 2017 presentation.

Acquisitions and Divestitures

On December 19, 2017, we announced that we have entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division (Kindred at Home) of Kindred Healthcare, Inc. (Kindred)(NYSE: KND), the nation's largest home health provider and second largest hospice operator, for estimated cash consideration of approximately $800 million, including our share of transaction and related expenses, to facilitate a complete separation from the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital company).

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies. See Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, for a discussion of our closed block of long-term care insurance policies.

These transactions are more fully discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Business Segments

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to

evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health and voluntary insurance benefits, and financial protection products, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health. The Individual Commercial segment consists of our individual commercial fully-insured medical health insurance benefits. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

The results of each segment are measured by income before income taxes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail, Group and Specialty, and Individual Commercial segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low

income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare marketing season.

Our Group and Specialty segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group and Specialty segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses.

Certain of our fully-insured individual commercial medical products in our Individual Commercial segment experience seasonality in the benefit ratio similar to the Group and Specialty segment, including the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers. As previously underwritten members transition, it results in policy lapses and the release of reserves for future policy benefits partially offset by the recognition of previously deferred acquisition costs. The recognition of a premium deficiency reserve for our Individual Commercial medical business compliant with the Health Care Reform Law in the fourth quarter of 2015, and subsequent changes in estimate, also impacted the quarterly benefit ratio pattern for this business in 2016.

Highlights

Consolidated

- Our 2017 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2017, approximately 1,901,300 members, or 66.5%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,816,300 members, or 64.0%, at December 31, 2016.

- Our consolidated pretax results of $4.02 billion for 2017, an increase of $2.47 billion, from $1.55 billion in 2016, primarily reflects the net gain associated with the terminated Merger Agreement, mainly the break-up fee, along with the year-over-year improvement in earnings for our Individual Commercial, Retail and Group and Specialty segments. The year-over-year comparison was also favorably impacted by the reserve strengthening for our non-strategic closed block of long-term care insurance business recorded in 2016. These items were partially offset by lower pretax earnings in the Healthcare Services segment, charges associated with voluntary and involuntary workforce reduction programs recorded during the second half of 2017, as well as the estimated guaranty fund assessment expense to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company).

- Year-over-year comparisons of diluted earnings per common share reflect the same factors impacting our consolidated pretax income comparisons year-over-year as well as the beneficial effect of the lower effective tax rate in light of pricing and benefit design assumptions associated with the 2017 temporary suspension of the health insurance industry fee. In addition the year-over-year comparisons were favorably impacted by lower number of shares, primarily reflecting share repurchases.

- We recorded a net gain associated with the terminated Merger Agreement, consisting primarily of the breakup fee, of approximately $936 million, or $4.31 per diluted common share, during 2017. During 2016, we recorded transaction costs in connection with the Merger of approximately $104 million, or $0.64 per diluted common share. Certain costs associated with the Merger were previously not deductible for tax purposes, but became deductible, and were recorded as such, in the first quarter 2017 as a result of the termination of the Merger Agreement.

- During 2017, we initiated a voluntary early retirement program and an involuntary workforce reduction program. These programs impacted approximately 3,600 associates, or 7.8% of our workforce. As a result, we recorded charges of $148 million, or $0.64 per diluted common share. This charge is included with operating costs in the consolidated statements of income for the year ended December 31, 2017 and included at the corporate level in the segment financial information. Payments under these programs are made upon termination during the early retirement or severance pay period, beginning in the first quarter of 2018. We expect this liability to be primarily paid within the next 12 months and classified it as a current liability, included in our consolidated balance sheet in the trade accounts payable and accrued expenses line.

- On March 1, 2017, a court ordered the liquidation of Penn Treaty (an unaffiliated long-term care insurance company), which triggered assessments from state guaranty associations that resulted in our recording a $54 million, or $0.24 per diluted common share, charge in operating costs.

- The annual health insurance industry fee has been suspended for calendar year 2017 but has resumed in calendar year 2018. Operating cost associated with the health insurer fee attributable to 2016 was $916 million. This fee is not deductible for tax purposes, which significantly increased our effective income tax rate. The one-year suspension in 2017 of the health insurer fee has significantly reduced our operating costs and effective tax rate during 2017. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurer fee, but the fee is scheduled to resume in calendar year 2020.

- Investment income increased $16 million in 2017, primarily due to higher average invested balances and interest rates in 2017, partially offset by lower realized capital gains.

- Operating cash flow provided by operations was $4.1 billion for the year ended December 31, 2017 as compared to operating cash flow provided by operations of $1.9 billion for the year ended December 31, 2016. The increase in operating cash flow primarily was due to the receipt of the merger termination fee, net of related expenses and taxes paid, higher earnings and the timing of working capital items.

- We paid dividends to stockholders of $220 million in 2017 as compared to $177 million in 2016.

Retail Segment

- In 2017, our Retail segment pretax income increased by $288 million, or 17.0%, from 2016 primarily driven by the year-over-year improvement in our Medicare Advantage business.

- On February 1, 2018, CMS issued its preliminary 2019 Medicare Advantage and Part D payment rates and proposed policy changes, which we refer to collectively as the Advance Notice. CMS has invited public comment on the Advance Notice before publishing final rates on April 2, 2018 (the Final Notice). In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 1.84 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county re-basing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. CMS' estimate includes 30 basis points of negative impact associated with the proposed Employer Group Waiver Plan Payment Policy for 2019. Excluding that item, CMS' estimate would be a 2.14 percent increase. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS' web site, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate, excluding the impact attributable to the Employer Group Waiver Plan Payment Policy.

Group and Specialty Segment

- Group and Specialty segment pretax income was $412 million in 2017, an increase of $68 million, or 19.8%, from $344 million in 2016 primarily reflecting the impact of higher pretax earnings associated with our fully-insured commercial medical products as well as higher earnings from our military services business resulting from higher performance incentives earned under the TRICARE contract.
- On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The T2017 East contract is a 5-year contract set to expire on December 31, 2022.

Healthcare Services Segment

- Healthcare Services segment pretax income was $967 million in 2017, a decrease $129 million, or 11.8%, from 2016 primarily due to the impact of the optimization process associated with our chronic care management programs, as well as lower earnings in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. The reductions in pharmacy solutions intersegment revenues were offset by similar reductions in operating costs associated with the pharmacy solutions business.
- At December 31, 2017, approximately 52,200 primary care providers were in value-based relationships, an increase of 3.6% from 50,400 at December 31, 2016. At December 31, 2017, 66% of our individual Medicare Advantage members were in value-based relationships compared to 64% at December 31, 2016.
- Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 794,900 at December 31, 2017, a decrease of 27.7% from 1,099,200 at December 31, 2016. We have undergone an optimization process that ensures the appropriate level of member interaction with clinicians to drive quality outcomes, which has resulted in reduced segment earnings but higher returns on investment.

Individual Commercial Segment

- As announced on February 14, 2017, we exited our Individual Commercial medical business January 1, 2018.
- In 2017, our Individual Commercial segment pretax income was $193 million, an increase of $1.1 billion, from a pretax loss of $869 million in 2016 primarily due to the exit of certain markets in 2017, and per-member premium increases, as well as the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry is $14.3 billion in 2018 and is not deductible for income tax purposes, which significantly increases our effective income tax rate. A one year suspension in 2017 and 2019 of the health insurer fee significantly impacts our trend in key operating metrics including our operating cost and medical expense ratios, as well as our effective tax rate.

In addition, the Health Care Reform Law expands federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which

began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this 2017 Form 10-K.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. For 2017, we offered on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. Effective January 1, 2018, we have exited our remaining Individual Commercial medical business.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur. We may be unable to adjust our product offerings, geographic footprint, or pricing during any given year such legislative changes occur in sufficient time to mitigate any adverse effects.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2017, we collected approximately $39 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail, Group and Specialty, and Individual Commercial segment customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2017 Form 10-K.

Comparison of Results of Operations for 2017 and 2016

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2017 and 2016:

Consolidated

	2017	2016	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 44,626	$ 43,223	$ 1,403	3.2 %
Group and Specialty	6,772	6,696	76	1.1 %
Individual Commercial	947	3,064	(2,117)	(69.1)%
Other Businesses	35	38	(3)	(7.9)%
Total premiums	52,380	53,021	(641)	(1.2)%
Services:				
Retail	10	6	4	66.7 %
Group and Specialty	626	643	(17)	(2.6)%
Healthcare Services	338	310	28	9.0 %
Other Businesses	8	10	(2)	(20.0)%
Total services	982	969	13	1.3 %
Investment income	405	389	16	4.1 %
Total revenues	53,767	54,379	(612)	(1.1)%
Operating expenses:				
Benefits	43,496	45,007	(1,511)	(3.4)%
Operating costs	6,567	7,173	(606)	(8.4)%
Merger termination fee and related costs, net	(936)	104	(1,040)	(1,000.0)%
Depreciation and amortization	378	354	24	6.8 %
Total operating expenses	49,505	52,638	(3,133)	(6.0)%
Income from operations	4,262	1,741	2,521	144.8 %
Interest expense	242	189	53	28.0 %
Income before income taxes	4,020	1,552	2,468	159.0 %
Provision for income taxes	1,572	938	634	67.6 %
Net income	$ 2,448	$ 614	$ 1,834	298.7 %
Diluted earnings per common share	$ 16.81	$ 4.07	$ 12.74	313.0 %
Benefit ratio (a)	83.0%	84.9%		(1.9)%
Operating cost ratio (b)	12.3%	13.3%		(1.0)%
Effective tax rate	39.1%	60.5%		(21.4)%

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income for 2017 was $2.4 billion, or $16.81 per diluted common share compared to $614 million, or $4.07 per diluted common share, in 2016. Net income in 2017 includes a net gain of $4.31 per diluted common share associated with the terminated Merger Agreement consisting primarily of the break-up fee, and the beneficial effect of the lower effective tax rate in light of pricing and benefit design assumptions with the temporary suspension of the health insurance industry fee of $2.15 per diluted common share, excluding the Individual Commercial business impact. The year-over-year comparison was also favorably impacted by a write-off of $2.43 per diluted common share in receivables associated with the commercial risk corridor premium stabilization program, and the reserve strengthening for our non-strategic closed block of long-term care insurance business of $2.11 per common diluted share recorded in 2016. These items were partially offset by the impact of the tax reform law enacted on December 22, 2017, or the Tax Reform Law, which resulted in the reduction of our net income due to the remeasurement of deferred tax assets at lower enacted corporate tax rates of $0.92 per diluted common share, $0.64 per common diluted share in charges associated with both voluntary and involuntary workforce reduction programs in 2017, as well as the estimated guaranty fund assessment expense to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company) of $0.24 per diluted common share. Excluding the impacts of the items above, the increase in net income primarily was due to year-over-year improvements in earnings for our Individual Commercial, Retail, and Group and Specialty segments, partially offset by lower earnings in the Healthcare Services segment.

Premiums Revenue

Consolidated premiums decreased $641 million, or 1.2%, from 2016 to $52.4 billion for 2017 primarily due to lower premiums in the Individual Commercial segment, partially offset by higher premiums in the Retail segment, primarily resulting from growth in our Medicare Advantage business, and higher premiums in the Group and Specialty segment, as discussed in the detailed segment results discussion that follows.

Services Revenue

Consolidated services revenue increased $13 million, or 1.3%, from 2016 for 2017 primarily due to an increase in services revenue in the Healthcare Services segment, partially offset by a decrease in services revenue in the Group and Specialty segment as discussed in the detailed segment results discussion that follows.

Investment Income

Investment income was $405 million for 2017, increasing $16 million, or 4.1%, from 2016, primarily due higher average invested balances and interest rates in 2017, partially offset by lower realized capital gains.

Benefits Expense

Consolidated benefits expense was $43.5 billion for 2017, a decrease of $1.5 billion, or 3.4%, from 2016 reflecting $505 million in incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies recorded in 2016. Excluding the long-term care reserve strengthening in 2016, the decrease primarily was due to a decrease in the Individual Commercial segment benefits expense, partially offset by an increase in the Retail and Group and Specialty segments benefits expense as discussed in the detailed segment results discussion that follows. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017 and $582 million in 2016.

The consolidated benefit ratio for 2017 was 83.0%, a decrease of 190 basis points from 2016 primarily due to the incremental benefits expense in 2016 for the reserve strengthening in our non-strategic closed block of long-term care insurance policies. Excluding the impact of the above, the decrease in the consolidated benefit ratio primarily was due to the decrease in the Individual Commercial segment benefit ratio, partially offset by the increase in the Retail and Group and Specialty segment benefit ratio as discussed in the segment results of operation discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 90 basis points in 2017 versus approximately 110 basis points in 2016.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs decreased $606 million, or 8.4%, from 2016 to $6.6 billion in 2017 primarily due to the temporary suspension of the health insurance industry fee for the calendar year 2017 and lower Individual Commercial membership. This was partially offset by charges associated with both voluntary and involuntary workforce reduction programs, an increase in employee compensation costs resulting from the continued strong performance, increased spending associated with the Medicare Annual Election Period, or AEP, as well as the estimated guaranty fund assessment expense recorded to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company).

The consolidated operating cost ratio for 2017 was 12.3%, decreasing 100 basis points from 2016 primarily due to the temporary suspension of the health insurance industry fee for the calendar year 2017, the write-off of receivables associated with the commercial risk corridor premium stabilization program in 2016, as well as operating cost efficiencies, partially offset by the loss of scale efficiency from market exits in the 2017 period associated with the Individual Commercial product, the estimated charges associated with both voluntary and involuntary workforce reduction programs recorded in 2017, increased employee compensation costs resulting from the continued strong performance, as well as the impact of the estimated guaranty fund assessment expense recorded to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company). The non-deductible health insurance industry fee impacted the operating cost ratio by 170 basis points in 2016.

Depreciation and Amortization

Depreciation and amortization for 2017 of $378 million was relatively unchanged from 2016.

Interest Expense

Interest expense was $242 million for 2017 compared to $189 million for 2016, an increase of $53 million, or 28.0%, due to the issuance of $1.8 billion in senior notes, a portion of the proceeds which were used to redeem $800 million of senior notes scheduled to mature in 2018. We recognized a loss on extinguishment of debt of approximately $17 million in December 2017 for the redemption of these senior notes, which is included in interest expense.

Income Taxes

Our effective tax rate during 2017 was 39.1% compared to the effective tax rate of 60.5% in 2016 primarily reflecting the suspension of the annual health insurance industry fee in 2017, as well as previously non-deductible transaction costs that, as a result of termination of the Merger Agreement, became deductible for tax purposes and were recorded as such in the first quarter of 2017, partially offset by the Tax Reform Law, which increased our effective tax rate due to the remeasurement of deferred tax assets at lower enacted corporate tax rates. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

The tax reform law enacted on December 22, 2017 significantly reduced our federal corporate tax rate. As a result, we expect our effective tax rate for 2018 to be approximately 32.5% to 33.5%. The decline in the effective tax rate for 2018 primarily is due to the enactment of tax reform, partially offset by the resumption of the annual health insurance industry fee in 2018.

Retail Segment

	2017	2016	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,860,800	2,837,600	23,200	0.8 %
Group Medicare Advantage	441,400	355,400	86,000	24.2 %
Medicare stand-alone PDP	5,308,100	4,951,400	356,700	7.2 %
Total Retail Medicare	8,610,300	8,144,400	465,900	5.7 %
State-based Medicaid	360,100	388,100	(28,000)	(7.2)%
Medicare Supplement	235,900	218,800	17,100	7.8 %
Total Retail medical members	9,206,300	8,751,300	455,000	5.2 %

	2017	2016	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 32,720	$ 31,863	$ 857	2.7 %
Group Medicare Advantage	5,155	4,283	872	20.4 %
Medicare stand-alone PDP	3,702	4,009	(307)	(7.7)%
Total Retail Medicare	41,577	40,155	1,422	3.5 %
State-based Medicaid	2,571	2,640	(69)	(2.6)%
Medicare Supplement	478	428	50	11.7 %
Total premiums	44,626	43,223	1,403	3.2 %
Services	10	6	4	66.7 %
Total premiums and services revenue	$ 44,636	$ 43,229	$ 1,407	3.3 %
Income before income taxes	$ 1,978	$ 1,690	$ 288	17.0 %
Benefit ratio	85.6%	85.1%		0.5 %
Operating cost ratio	9.6%	10.8%		(1.2)%

Pretax Results

- Retail segment pretax income was $2.0 billion in 2017, an increase of $288 million, or 17.0%, compared to 2016 primarily driven by the year-over-year improvement in our Medicare Advantage business.

Enrollment

- Individual Medicare Advantage membership increased 23,200 members, or 0.8%, from December 31, 2016 to December 31, 2017 reflecting net membership additions for Medicare beneficiaries including the effect of planned market and product exits in 2017. We decided certain markets and/or products were not meeting long term strategic and financial objectives. Additionally, membership growth was muted due to competitive actions including the uncertainty associated with the then-pending Merger transaction during last year's AEP. For full year 2018, we anticipate net membership growth in our individual Medicare Advantage offerings of 180,000 to 200,000.
- Group Medicare Advantage membership increased 86,000 members, or 24.2%, from December 31, 2016 to December 31, 2017 reflecting the addition of a large account in January 2017. For full year 2018, we anticipate net membership growth in our group Medicare Advantage offerings of 65,000 to 70,000.

- Medicare stand-alone PDP membership increased 356,700 members, or 7.2%, from December 31, 2016 to December 31, 2017 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2017 plan year. For full year 2018, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of 280,000 to 320,000, primarily attributable to the loss of auto assign members in Florida and South Carolina due to pricing over the CMS low income benchmark and continued membership declines in our Enhanced Plan offering.

- State-based Medicaid membership decreased 28,000 members, or 7.2%, from December 31, 2016 to December 31, 2017, primarily driven by lower membership associated with our Florida contracts resulting from network realignments.

Premiums revenue

- Retail segment premiums increased $1.4 billion, or 3.2%, from 2016 to 2017 primarily due to Medicare Advantage membership growth and increased per-member premiums for certain of the segment's products. Average group and individual Medicare Advantage membership increased 3.4% in 2017. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per-member premiums. Items impacting average per-member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Benefits expense

- The Retail segment benefit ratio of 85.6% for 2017 increased 50 basis points from 2016 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing and benefit design of our products, margin compression associated with the competitive environment in the group Medicare Advantage business and slightly lower favorable prior-period medical claims reserve development. These increases were partially offset by the impact of planned exits from certain Medicare Advantage markets that carried a higher benefit ratio than other markets as well as lower than expected medical costs as compared to the assumptions used in the pricing of our individual Medicare Advantage business.

- The Retail segment's benefits expense for 2017 included the beneficial effect of $386 million in favorable prior-year medical claims reserve development versus $429 million in 2016. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 90 basis points in 2017 versus approximately 100 basis points in 2016.

Operating costs

- The Retail segment operating cost ratio of 9.6% for 2017 decreased 120 basis points from 2016 primarily due to the temporary suspension of the health insurance industry fee for calendar year 2017, partially offset by increased spending associated with AEP, investments in our integrated care delivery model, and the increase in employee compensation costs resulting from the continued strong performance. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016.

Group and Specialty Segment

	2017	2016	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,097,700	1,136,000	(38,300)	(3.4)%
ASO	458,700	573,200	(114,500)	(20.0)%
Military services	3,081,800	3,084,100	(2,300)	(0.1)%
Total group medical members	4,638,200	4,793,300	(155,100)	(3.2)%
Specialty membership (a)	6,986,000	6,961,200	24,800	0.4 %

(a) Specialty products include dental, vision, voluntary benefit products and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2017	2016	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,462	$ 5,405	$ 57	1.1 %
Specialty	1,310	1,279	31	2.4 %
Military services	—	12	(12)	(100.0)%
Total premiums	6,772	6,696	76	1.1 %
Services	626	643	(17)	(2.6)%
Total premiums and services revenue	$ 7,398	$ 7,339	$ 59	0.8 %
Income before income taxes	$ 412	$ 344	$ 68	19.8 %
Benefit ratio	79.2%	78.2%		1.0 %
Operating cost ratio	21.4%	23.5%		(2.1)%

Pretax Results

- Group and Specialty segment pretax income was $412 million in 2017, an increase of $68 million, or 19.8%, from $344 million in 2016 primarily reflecting the impact of higher pretax earnings associated with our fully-insured commercial business as well as higher earnings from our military services business resulting from higher performance incentives earned under the TRICARE contract.

Enrollment

- Fully-insured commercial group medical membership decreased 38,300 members, or 3.4% from December 31, 2016 reflecting lower membership in small group accounts due in part to more small group accounts selecting ASO products in 2017.
- Group ASO commercial medical membership decreased 114,500 members, or 20.0%, from December 31, 2016 to December 31, 2017 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment, partially offset by more small group accounts selecting ASO products in 2017.
- Specialty membership increased 24,800 members, or 0.4%, from December 31, 2016 to December 31, 2017 primarily due to strong growth in vision products marketed to employer groups.

Premiums revenue

- Group and Specialty segment premiums increased $76 million, or 1.1%, from 2016 to 2017 primarily due to an increase in group fully-insured commercial medical per-member premiums, partially offset by a decline in average group fully-insured commercial medical membership.

Services revenue

- Group and Specialty segment services revenue decreased $17 million, or 2.6%, from 2016 to 2017 primarily due to a decline in revenue in our group ASO commercial medical business mainly due to membership declines partially offset by higher revenue from our military services business resulting from higher performance incentives earned under the TRICARE contract.

Benefits expense

- The Group and Specialty segment benefit ratio increased 100 basis points from 78.2% in 2016 to 79.2% in 2017 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing of our products. The increase was further impacted by an increased proportion of small group members transitioning to community rated plans that carry a higher benefit ratio. These increases were partially offset by lower utilization for the fully-insured commercial medical business in 2017, primarily associated with the large group business.
- The Group and Specialty segment's benefits expense included the beneficial effect of $40 million in favorable prior-year medical claims reserve development in 2017 versus $46 million in 2016. This favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 60 basis points in 2017 versus approximately 70 basis points in 2016.

Operating costs

- The Group and Specialty segment operating cost ratio of 21.4% for 2017 decreased 210 basis points from 23.5% for 2016 primarily due to the temporary suspension of the health insurance industry fee for calendar year 2017 as well as operating cost efficiencies, partially offset by an increase in employee compensation costs resulting from the continued strong performance. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016.

Healthcare Services Segment

	2017	2016	Change	
			Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 181	$ 201	$ (20)	(10.0)%
Pharmacy solutions	80	31	49	158.1 %
Provider services	77	78	(1)	(1.3)%
Total services revenues	338	310	28	9.0 %
Intersegment revenues:				
Pharmacy solutions	20,881	21,952	(1,071)	(4.9)%
Provider services	1,593	1,677	(84)	(5.0)%
Clinical care services	1,111	1,343	(232)	(17.3)%
Total intersegment revenues	23,585	24,972	(1,387)	(5.6)%
Total services and intersegment revenues	$ 23,923	$ 25,282	$ (1,359)	(5.4)%
Income before income taxes	$ 967	$ 1,096	$ (129)	(11.8)%
Operating cost ratio	95.5%	95.2%		0.3 %

Pretax results

- Healthcare Services segment pretax income was $967 million in 2017, a decrease of $129 million, or 11.8%, from 2016 primarily was due to the impact of the optimization process associated with our chronic care management programs, as well as lower earnings in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. The reductions in pharmacy solutions intersegment revenues were offset by similar reductions in operating costs associated with the pharmacy solutions business.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 433 million in 2017, up 2% versus scripts of approximately 426 million in 2016. The increase primarily reflects growth associated with higher Medicare membership for 2017 than in 2016, partially offset by the decline in Individual Commercial membership.

Services revenue

- Services revenue increased $28 million, or 9.0%, from 2016 to $338 million for 2017 primarily due to service revenue growth from our pharmacy solutions business.

Intersegment revenues

- Intersegment revenues decreased $1.4 billion, or 5.6%, from 2016 to $23.6 billion for 2017 primarily due to our pharmacy solutions business as well as the result of the optimization process associated with our chronic care management programs discussed previously, as well as lower revenue in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. Our pharmacy solutions business revenues were impacted by improvements in net pharmacy costs driven by our pharmacy benefit manager and an increase in the generic dispensing rate. These items were partially offset by higher year-over-year script volume from growth in our Medicare Advantage and standalone PDP membership, partially offset by the impact of lower Individual Commercial membership. Our generic dispensing rate improved to 91.3% during 2017 from 90.5% during 2016. The higher generic dispensing rate

reduced revenues (and operating costs) for our pharmacy solutions business as generic drugs are generally priced lower than branded drugs.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.5% for 2017 was relatively unchanged from 95.2% for 2016.

Individual Commercial Segment

- As announced on February 14, 2017, we exited our Individual Commercial medical business January 1, 2018.
- In 2017, our Individual Commercial segment pretax income was $193 million, an increase of $1.1 billion, from a pretax loss of $869 million in 2016 primarily due to the exit of certain markets in 2017, and per-member premium increases, as well as the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program.
- Individual commercial medical membership decreased 526,000 members, or 80.3%, from December 31, 2016 to December 31, 2017 reflecting the decline in the number of counties we offered on-exchange coverage and the discontinuance of offering off-exchange products.
- The Individual Commercial segment benefit ratio of 57.4% for 2017 decreased from 107.7% in 2016 primarily due to the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program, as well as the planned exits in 2017 in certain markets that carried a higher benefit ratio and per-member premium increases.
- The Individual Commercial segment operating cost ratio of 21.2% for 2017 increased 160 basis points from 2016 primarily due to the loss of scale efficiency from market exits in 2017, partially offset by the write-off of receivables associated with the commercial risk corridor premium stabilization program and the temporary suspension of the health insurance industry fee for calendar year 2017.

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2017 Form 10-K.

Comparison of Results of Operations for 2016 and 2015

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2016 and 2015:

Consolidated

	2016	2015	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 43,223	$ 41,605	$ 1,618	3.9 %
Group and Specialty	6,696	6,830	(134)	(2.0)%
Individual Commercial	3,064	3,939	(875)	(22.2)%
Other Businesses	38	35	3	8.6 %
Total premiums	53,021	52,409	612	1.2 %
Services:				
Retail	6	8	(2)	(25.0)%
Group and Specialty	643	658	(15)	(2.3)%
Healthcare Services	310	726	(416)	(57.3)%
Other Businesses	10	14	(4)	(28.6)%
Total services	969	1,406	(437)	(31.1)%
Investment income	389	474	(85)	(17.9)%
Total revenues	54,379	54,289	90	0.2 %
Operating expenses:				
Benefits	45,007	44,269	738	1.7 %
Operating costs	7,173	7,295	(122)	(1.7)%
Merger termination fee and related costs, net	104	23	81	352.2 %
Depreciation and amortization	354	355	(1)	(0.3)%
Total operating expenses	52,638	51,942	696	1.3 %
Income from operations	1,741	2,347	(606)	(25.8)%
Gain on sale of business	—	270	(270)	(100.0)%
Interest expense	189	186	3	1.6 %
Income before income taxes	1,552	2,431	(879)	(36.2)%
Provision for income taxes	938	1,155	(217)	(18.8)%
Net income	$ 614	$ 1,276	$ (662)	(51.9)%
Diluted earnings per common share	$ 4.07	$ 8.44	$ (4.37)	(51.8)%
Benefit ratio (a)	84.9%	84.5%		0.4 %
Operating cost ratio (b)	13.3%	13.6%		(0.3)%
Effective tax rate	60.5%	47.5%		13.0 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income was $614 million, or $4.07 per diluted common share, in 2016 compared to $1.3 billion, or $8.44 per diluted common share, in 2015. Net income includes a write-off of $2.43 per diluted common share in receivables associated with the commercial risk corridor premium stabilization program and reserve strengthening for our non-strategic closed block of long-term care insurance business of $2.11 per diluted common share, as discussed below. These items were partially offset by the impact of the premium deficiency reserve of $0.74 per diluted common share recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. In addition, the completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain of $1.57 per diluted common share in 2015. Excluding these items, the increase primarily was due to year-over-year improvement in results for our individual Medicare Advantage business and our Healthcare Services segment as well as increased profitability in our state-based Medicaid business, partially offset by an increase in the effective tax rate as discussed below. In addition, 2016 includes expenses of $0.64 per diluted common share and 2015 includes expenses of $0.14 per diluted common share for transaction and integration planning costs associated with the Merger, certain of which were not deductible for tax purposes until 2017.

Premiums Revenue

Consolidated premiums increased $612 million, or 1.2%, from 2015 to $53.0 billion for 2016 primarily reflecting higher premiums in the Retail segment mainly driven by average membership growth and per member premium increases for certain of our lines of business. These increases were partially offset by the write-off of $583 million of receivables associated with the commercial risk corridor premium stabilization program, the loss of premiums associated with a large group Medicare account that moved to a private exchange on January 1, 2016, and a decline in premiums revenue associated with fewer individual commercial medical members as discussed in our segment results of operations discussion that follows. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

Consolidated services revenue decreased $437 million, or 31.1%, from 2015 to $1.0 billion for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Investment Income

Investment income totaled $389 million for 2016, a decrease of $85 million, or 17.9%, from 2015, primarily due to lower realized capital gains in 2016 and lower interest rates partially offset by a higher average invested balance.

Benefits Expense

Consolidated benefits expense was $45.0 billion for 2016, an increase of $738 million, or 1.7%, from 2015 primarily due to $505 million in incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies partially offset by the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the long-term care reserve strengthening and impact of the premium deficiency reserve, the increase is primarily due to an increase in the Retail segment mainly driven by higher average individual Medicare Advantage membership. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016 and $236 million in 2015. The increase in prior-period medical claims reserve development year over-year primarily was due to favorable year-over-year comparisons for our Medicare Advantage and individual commercial medical businesses.

The consolidated benefit ratio for 2016 was 84.9%, an increase of 40 basis points from 2015 primarily due to the incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies, the impact on the benefit ratio of lower consolidated premiums associated with the write-off of receivables for the commercial risk corridor premium stabilization program, and the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the impact of the write-off of the commercial risk corridor receivables and the premium deficiency reserve, these items were partially offset by year-over-year improvement in both the Retail and Group and Specialty segment benefit ratios as discussed in the segment results of operations discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 110 basis points in 2016 versus approximately 50 basis points in 2015.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs decreased $122 million, or 1.7%, from 2015 to $7.2 billion in 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

The consolidated operating cost ratio for 2016 was 13.3%, decreasing 30 basis points from 2015 primarily due to the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio than our Group and Specialty and Retail segments. This was partially offset by the unfavorable year-over-year comparison associated with the temporary suspension of certain discretionary administrative costs in the latter half of 2015, along with the impact of the commercial risk corridor receivables write-off in the fourth quarter of 2016.

Depreciation and Amortization

Depreciation and amortization for 2016 of $354 million was relatively unchanged from 2015.

Interest Expense

Interest expense was $189 million for 2016 compared to $186 million for 2015, an increase of $3 million, or 1.6%.

Income Taxes

Our effective tax rate during 2016 was 60.5% compared to the effective tax rate of 47.5% in 2015 primarily reflecting lower pretax income year-over-year, the beneficial effect of the sale of Concentra on June 1, 2015 and the impact of non-deductible transaction costs associated with the Merger. Non-deductible transaction and integration planning costs associated with the Merger increased our effective tax rate by approximately 3.4 percentage points in 2016 versus approximately 0.4 percentage points in 2015. Conversely, the tax effect of the sale of Concentra reduced our effective tax rate by approximately 4.5 percentage points in 2015. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

The effective tax rate for 2016 also reflects tax benefits associated with adopting new guidance related to the accounting for employee share-based payments effective January 1, 2016 as described in Note 2 to the condensed consolidated financial statements included in this report, which decreased our effective tax rate by approximately 1.2 percentage points in 2016.

Retail Segment

	2016	2015	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,837,600	2,753,400	84,200	3.1 %
Group Medicare Advantage	355,400	484,100	(128,700)	(26.6)%
Medicare stand-alone PDP	4,951,400	4,557,900	393,500	8.6 %
Total Retail Medicare	8,144,400	7,795,400	349,000	4.5 %
State-based Medicaid	388,100	373,700	14,400	3.9 %
Medicare Supplement	218,800	158,600	60,200	38.0 %
Total Retail medical members	8,751,300	8,327,700	423,600	5.1 %

	2016	2015	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 31,863	$ 29,526	$ 2,337	7.9 %
Group Medicare Advantage	4,283	5,588	(1,305)	(23.4)%
Medicare stand-alone PDP	4,009	3,846	163	4.2 %
Total Retail Medicare	40,155	38,960	1,195	3.1 %
State-based Medicaid	2,640	2,341	299	12.8 %
Medicare Supplement	428	304	124	40.8 %
Total premiums	43,223	41,605	1,618	3.9 %
Services	6	8	(2)	(25.0)%
Total premiums and services revenue	$ 43,229	$ 41,613	$ 1,616	3.9 %
Income before income taxes	$ 1,690	$ 1,259	$ 431	34.2 %
Benefit ratio	85.1%	86.7%		(1.6)%
Operating cost ratio	10.8%	10.3%		0.5 %

Pretax Results

- Retail segment pretax income was $1,690 million in 2016, an increase of $431 million, or 34.2%, compared to 2015 primarily driven by the year-over-year improvement in our individual Medicare Advantage and state-based Medicaid businesses.

Enrollment

- Individual Medicare Advantage membership increased 84,200 members, or 3.1%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, particularly for our HMO offerings, for the 2016 plan year.
- Group Medicare Advantage membership decreased 128,700 members, or 26.6%, from December 31, 2015 to December 31, 2016 reflecting the loss of a large account that moved to a private exchange offering on January 1, 2016.

- Medicare stand-alone PDP membership increased 393,500 members, or 8.6%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2016 plan year.
- State-based Medicaid membership increased 14,400 members, or 3.9%, from December 31, 2015 to December 31, 2016 primarily driven by the addition of members under our Florida Medicaid contract.

Premiums revenue

- Retail segment premiums increased $1,618 million, or 3.9%, from 2015 to 2016 primarily due to higher average membership for our individual Medicare Advantage and state-based Medicaid businesses and per member premium increases for certain lines of business. Average individual Medicare Advantage membership increased 3.9% in 2016.

Benefits expense

- The Retail segment benefit ratio of 85.1% for 2016 decreased 160 basis points from 2015 primarily due to lower year-over-year Medicare Advantage utilization, and favorable comparisons of prior-year medical claims reserve development.
- The Retail segment's benefits expense for 2016 included the beneficial effect of $429 million in favorable prior-year medical claims reserve development versus $248 million in 2015. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 100 basis points in 2016 versus approximately 60 basis points in 2015. The year-over-year increase in prior-period medical claims reserve development primarily was due to favorable year-over-year comparisons for our Medicare Advantage business.

Operating costs

- The Retail segment operating cost ratio of 10.8% for 2016 increased 50 basis points from 2015 primarily due to the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs, and the loss of a large group Medicare Advantage account which carried a lower operating cost ratio than that for our individual Medicare Advantage business. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016 as compared to 160 basis points in 2015.

Group and Specialty Segment

			Change	
	2016	2015	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,136,000	1,178,300	(42,300)	(3.6)%
ASO	573,200	710,700	(137,500)	(19.3)%
Military services	3,084,100	3,074,400	9,700	0.3 %
Total group medical members	4,793,300	4,963,400	(170,100)	(3.4)%
Specialty membership (a)	6,961,200	7,221,800	(260,600)	(3.6)%

(a) Specialty products include dental, vision, voluntary benefit products and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2016	2015	Change	
			Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,405	$ 5,493	$ (88)	(1.6)%
Specialty	1,279	1,316	(37)	(2.8)%
Military services	12	21	(9)	(42.9)%
Total premiums	6,696	6,830	(134)	(2.0)%
Services	643	658	(15)	(2.3)%
Total premiums and services revenue	$ 7,339	$ 7,488	$ (149)	(2.0)%
Income before income taxes	$ 344	$ 321	$ 23	7.2 %
Benefit ratio	78.2%	78.8%		(0.6)%
Operating cost ratio	23.5%	23.4%		0.1 %

Pretax Results

- Group and Specialty segment pretax income was $344 million in 2016, an increase of $23 million, or 7.2%, from $321 million in 2015 driven by the improvement in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 42,300 members, or 3.6% from December 31, 2015 reflecting lower membership in both large and small group accounts.
- Group ASO commercial medical membership decreased 137,500 members, or 19.3%, from December 31, 2015 to December 31, 2016 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.
- Specialty membership decreased 260,600 members, or 3.6%, from December 31, 2015 to December 31, 2016 primarily due to the loss of several large stand-alone dental and vision accounts as well as the loss of certain fully-insured group medical accounts that also had specialty coverage. The decrease includes the loss of certain individual commercial medical members that also had specialty coverage.

Premiums revenue

- Group and Specialty segment premiums decreased $134 million, or 2.0%, from 2015 to 2016 primarily due to a decline in fully-insured commercial medical membership as described above, partially offset by an increase in fully-insured commercial medical per member premiums.

Services revenue

- Group and Specialty segment services revenue decreased $15 million, or 2.3%, from 2015 to 2016 primarily due to a decline in group ASO commercial medical membership.

Benefits expense

- The Group and Specialty segment benefit ratio decreased 60 basis points from 78.8% in 2015 to 78.2% in 2016 primarily reflecting the beneficial effect of higher prior-year medical claims reserve development in 2016 and lower utilization.
- The Group and Specialty segment's benefits expense included the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2016 versus $7 million in 2015. This favorable prior-year

medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2016 versus approximately 10 basis points in 2015.

Operating costs

- The Group and Specialty segment operating cost ratio of 23.5% for 2016 increased 10 basis points from 23.4% for 2015, primarily due to the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016 as compared to 140 basis points in 2015.

Healthcare Services Segment

			Change	
	2016	2015	Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 201	$ 181	$ 20	11.0 %
Provider services	78	515	(437)	(84.9)%
Pharmacy solutions	31	30	1	3.3 %
Total services revenues	310	726	(416)	(57.3)%
Intersegment revenues:				
Pharmacy solutions	21,952	20,551	1,401	6.8 %
Provider services	1,677	1,291	386	29.9 %
Clinical care services	1,343	1,208	135	11.2 %
Total intersegment revenues	24,972	23,050	1,922	8.3 %
Total services and intersegment revenues	$ 25,282	$ 23,776	$ 1,506	6.3 %
Income before income taxes	$ 1,096	$ 1,022	$ 74	7.2 %
Operating cost ratio	95.2%	95.0%		0.2 %

Pretax results

- Healthcare Services segment pretax income of $1,096 million for 2016 increased $74 million, or 7.2%, from 2015 primarily due to incremental earnings associated with revenue growth from our pharmacy solutions business as it increased mail-order penetration and served our growing individual Medicare membership. The increase was partially offset by lower earnings in our provider services business reflecting significantly lower Medicare rates year-over-year associated with CMS' risk coding recalibration for 2016 in geographies where our provider assets are primarily located.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 426 million in 2016, up 7% versus scripts of approximately 398 million in 2015. The increase primarily reflects growth associated with higher average medical membership for 2016 than in 2015.

Services revenue

- Services revenue decreased $416 million, or 57.3%, from 2015 to $310 million for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $1.9 billion, or 8.3%, from 2015 to $25.0 billion for 2016 primarily due to increased mail order penetration and growth in our individual Medicare Advantage and Medicare stand-alone PDP membership which resulted in increased engagement of members in clinical programs and higher utilization of services across the segment.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.2% for 2016 increased slightly from 2015 primarily due to a higher operating cost ratio for our provider services business reflecting significantly lower Medicare rates year-over-year as discussed above, partially offset by operating cost efficiencies associated with our pharmacy operations.

Individual Commercial Segment

- In 2016, our Individual Commercial segment pretax loss decreased by $436 million, or 100.7%, from 2015 primarily driven by the write-off of commercial risk corridor receivables, partially offset by the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 associated with certain individual commercial medical policies from the 2016 coverage year.

- Individual commercial medical membership decreased 244,300 members, or 27.2%, from December 31, 2015 to December 31, 2016 primarily reflecting the loss of on-exchange members due to product competitiveness, the loss of membership associated with the discontinuance of certain Health Care Reform Law compliant plans in 2016, the loss of membership associated with non-payment of premiums or termination by CMS due to lack of eligibility documentation, and the loss of members subscribing to plans that are not compliant with the Health Care Reform Law.

- The Individual Commercial segment benefit ratio of 107.7% for 2016 increased from 91.1% in 2015 primarily due to the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program, partially offset by the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. As previously disclosed, in the fourth quarter of 2015 we recorded a premium deficiency reserve associated with our 2016 individual commercial offerings compliant with the Health Care Reform Law. During 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense primarily as a result of unfavorable current and projected claims experience.

- The Individual Commercial segment operating cost ratio of 19.6% for 2016 increased 40 basis points from 2015 primarily due to the impact on premiums of the write-off of receivables associated with the commercial risk corridor premium stabilization program. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 200 basis points in 2016 as compared to 170 basis points in 2015.

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Liquidity

Historically, our primary sources of cash have included receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities, borrowings, and proceeds from sales of businesses. Our primary uses of cash historically have included disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including premiums receivable, benefits payable, and other receivables and payables. Our cash flows are impacted by the timing of payments to and receipts from CMS associated with Medicare Part D subsidies for which we do not assume risk. The use of cash flows may be limited by regulatory requirements of state departments of insurance (or comparable state regulators) which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law have impacted the timing of our operating cash flows, as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. Net collections under the 3Rs associated with prior coverage years were $440 million in 2017 as compared to $383 million in 2016. As more fully described in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, we wrote off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2017, we collected approximately $39 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016. The remaining net receivable balance associated with the 3Rs was approximately $31 million at December 31, 2017, including the $44 million reinsurance receivable related to the 2016 coverage year, as compared to $456 million at December 31, 2016. The remaining net receivable balance is primarily related to our Individual Commercial medical business which we have exited January 1, 2018.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2017 Form 10-K.

Cash and cash equivalents increased to $4.0 billion at December 31, 2017 from $3.9 billion at December 31, 2016. The change in cash and cash equivalents for the years ended December 31, 2017, 2016 and 2015 is summarized as follows:

	2017	2016	2015
		(in millions)	
Net cash provided by operating activities	$ 4,051	$ 1,936	$ 868
Net cash (used in) provided by investing activities	(2,941)	(1,362)	320
Net cash (used in) provided by financing activities	(945)	732	(552)
Increase in cash and cash equivalents	$ 165	$ 1,306	$ 636

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The increase in operating cash flows in 2017 primarily was due to the receipt of the merger termination fee, net of related expenses and taxes paid, higher earnings and the timing of working capital items. The increase in operating cash flows in 2016 primarily was due to the timing of working capital items and higher earnings exclusive of the commercial risk corridor receivables write-off and the long-term care reserve strengthening in 2016, as well as the gain on sale of Concentra and the recognition of the premium deficiency reserve in 2015 discussed previously.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. We illustrate these changes with the following summaries of benefits payable and receivables.

The detail of benefits payable was as follows at December 31, 2017, 2016 and 2015:

				Change		
	2017	2016	2015	2017	2016	2015
			(in millions)			
IBNR (1)	$ 3,154	$ 3,422	$ 3,730	$ (268)	$ (308)	$ 476
Reported claims in process (2)	614	654	600	(40)	54	125
Premium deficiency reserve (3)	—	—	176	—	(176)	176
Other benefits payable (4)	900	487	470	413	17	(276)
Total benefits payable	$ 4,668	$ 4,563	$ 4,976	$ 105	$ (413)	$ 501

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).
(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.
(3) Premium deficiency reserve recognized for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.
(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increase in benefits payable in 2017 largely was due to an increase in amounts owed under capitated, risk sharing, and quality incentive arrangements, partially offset by a decrease in IBNR. Benefits payable decreased in 2016 primarily due to a decrease in IBNR, as well as the application of 2016 results to the premium deficiency reserve liability recognized in 2015 associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year. There was no premium deficiency reserve liability at December 31, 2016 or 2017. The increase in benefits payable in 2015 largely was due to increases in IBNR and in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuates due to month-end cutoff. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements in 2015, including the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. In addition, benefits payable in 2015 reflects the recognition of the premium deficiency reserve discussed previously.

IBNR decreased during 2017 and 2016 primarily due to declines in individual and fully-insured group commercial membership. The decrease in IBNR during 2016 was also impacted by declines in group Medicare Advantage. IBNR increased during 2015 primarily as a result of individual Medicare Advantage membership growth. As discussed previously, our cash flows are impacted by changes in enrollment. The decline in membership experienced in 2017 and 2016 negatively impacted operating cash flows for those years.

The detail of total net receivables was as follows at December 31, 2017, 2016 and 2015:

				Change		
	2017	2016	2015	2017	2016	2015
			(in millions)			
Medicare	$ 511	$ 787	$ 765	$ (276)	$ 22	$ 101
Commercial and other	273	579	420	(306)	159	39
Military services	166	32	77	134	(45)	(29)
Allowance for doubtful accounts	(96)	(118)	(101)	22	(17)	(3)
Total net receivables	$ 854	$ 1,280	$ 1,161	(426)	119	108
Reconciliation to cash flow statement:						
Provision for doubtful accounts				20	39	61
Change in receivables acquired, held-for-sale, or disposed from sale of business				—	—	11
Change in receivables per cash flow statement resulting in cash from operations				$ (406)	$ 158	$ 180

Medicare receivables are impacted by changes in revenue associated with individual and group Medicare membership changes as well as the timing of accruals and related collections associated with the CMS risk-adjustment model.

The decrease in commercial and other receivables in 2017 as compared to 2016 primarily was due to a decrease in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. The increases in commercial and other receivables in 2016 and 2015 primarily reflect increases in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law.

Military services receivables at December 31, 2017, 2016, and 2015 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our TRICARE South Region contract. The 2017 balance also includes transition-in receivables under our T2017 East Region contract with collection scheduled in 2018.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impacted our operating cash flows as we built receivables for each coverage year that were expected to be collected in subsequent coverage years. Net collections under the 3Rs associated with prior coverage years were $440 million as compared to net collections of $383 million in 2016. The net receivable balance associated with the 3Rs was approximately $31 million at December 31, 2017, including certain amounts recorded in receivables as noted above. The annual health insurance industry fee was suspended for the calendar year 2017, but has resumed in calendar year 2018. The annual health insurance industry fee was also suspended for the calendar year 2019 and is scheduled to resume in calendar year 2020. We paid the federal government annual health insurance industry fees of $916 million in 2016 and $867 million in 2015. We have exited our individual commercial medical business effective January 1, 2018.

In addition to the timing of payments of benefits expense, receipts for premiums and services revenues, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other items impacting operating cash flows include income tax payments and the timing of payroll cycles resulting in one less payroll cycle in 2016 than in 2015.

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $526 million in 2017, $527 million in 2016, and $523 million in 2015.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $2.4 billion in 2017 and $828 million in 2016. Proceeds from sales and maturities of investment securities exceeded purchases by $103 million in 2015. These net proceeds were used to fund normal working capital needs due to an increase in receivables associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below.

In 2015, we purchased a $284 million note receivable directly from a third-party bank syndicate related to the financing of MCCI Holdings, LLC's business as described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The purchase of this note is included with purchases of investment securities in our consolidated statement of cash flows.

On June 1, 2015, we completed the sale of Concentra for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs.

Cash consideration paid for acquisitions, net of cash acquired, was $31 million in 2017, $7 million in 2016, and $38 million in 2015. Acquisitions in each year included Healthcare Services segment related acquisitions.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were $1.9 billion higher than claims payments during 2017 and were $1.1 billion higher than claims payments during 2016. Claim payments were $361 million higher than receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk during 2015. In 2015, we experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher subsidy receivable balances under the terms of our contracts with CMS. Our net payable for CMS subsidies and brand name prescription drug discounts was $1.0 billion at December 31, 2017 compared to a net receivable of $0.9 billion at December 31, 2016. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our administrative services only TRICARE South Region contract, reimbursements from the federal government exceeded health care cost payments for which we do not assume risk by $11 million in 2017. Health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $25 million in 2016 and $4 million in 2015.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $44 million in 2017 and by $28 million in 2016. Claim payments were less than reimbursements by $69 million in 2015. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 12.99 million shares for $3.05 billion in 2017 and 1.85 million shares for $329 million in 2015 under share repurchase plans authorized by the Board of Directors. We did not repurchase shares in 2016 due to restrictions under the Merger Agreement. We also acquired common shares in connection with employee stock plans for an aggregate cost of $115 million in 2017, $104 million in 2016, and $56 million in 2015.

As discussed further below, we paid dividends to stockholders of $220 million in 2017, $177 million in 2016, and $172 million in 2015.

We entered into a commercial paper program in October 2014. Net repayments of commercial paper were $153 million in 2017 and the maximum principal amount outstanding at any one time during 2017 was $500 million. Net repayments of commercial paper were $2 million in 2016 and the maximum principal amount outstanding at any one time during 2016 was $475 million. Net proceeds from the issuance of commercial paper were $298 million in 2015 and the maximum principal amount outstanding at any one time during 2015 was $414 million.

In March 2017, we issued $600 million of 3.95% senior notes due March 15, 2027 and $400 million of 4.80% senior notes due March 15, 2047. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of March 31, 2017, were $991 million. The net proceeds from these issuances are being used for general corporate purposes.

In December 2017, we issued $400 million of 2.50% senior notes due December 15, 2020 and $400 million of 2.90% senior notes due December 15, 2022. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of December 31, 2017, were $794 million. We used the net proceeds, together with available cash, to fund the redemption of our $300 million aggregate principal amount of 6.30% senior notes maturing in August 2018 and our $500 million aggregate principal amount of 7.20% senior notes maturing in June 2018 at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $829 million.

The remainder of the cash used in or provided by financing activities in 2017, 2016, and 2015 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

For a detailed discussion of dividends to stockholders, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Stock Repurchases

For a detailed discussion of stock repurchases, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Debt

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Acquisitions & Divestitures

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies. We will fund the transaction with approximately $203 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $150 million of statutory capital with the sale. The KMG transaction is anticipated to close by the third quarter of 2018 subject to customary closing conditions, including South Carolina Department of Insurance approval. There can be no assurance we will obtain regulatory approvals needed to sell the business or do so under terms acceptable to us.

On December 19, 2017, we announced that we have entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division (Kindred at Home) of Kindred Healthcare, Inc. (Kindred)(NYSE: KND), the nation's largest home health provider and second largest hospice operator, for estimated cash consideration of approximately $800 million, including our share of transaction and related expenses, to facilitate a complete separation from the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital company). The Kindred transaction, which is anticipated to close in the summer of 2018, is subject to customary state and federal regulatory approvals, including approval by the stockholders of Kindred and the expiration of the waiting period under the Hart-Scott-Rodino Antitrust Improvement Act of 1976, as amended, as well as other customary closing conditions. We expect to fund the transaction through the use of parent company cash and will account for the minority investment under the equity method. The pending transaction did not have a material impact to earnings in 2017.

For a detailed discussion of the above please refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2017 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $688 million at December 31, 2017 from $2.0 billion at December 31, 2016. This decrease primarily reflects common stock repurchases, insurance subsidiaries' capital contributions and capital expenditures, partially offset by insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated subsidiaries paid dividends to the parent of $1.4 billion in 2017, $763 million in 2016, and $493 million in 2015. Subsidiary dividends in 2015 reflect the impact of losses for our individual commercial medical business compliant with the Health Care Reform Law and the November 5, 2015 revised statutory accounting guidance requiring the exclusion of risk corridor receivables from related statutory surplus. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2018 is approximately $1.1 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Our parent company funded a subsidiary capital contribution of approximately $535 million in the first quarter of 2017 for reserve strengthening associated with our closed block of long-term care insurance policies discussed further in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2017 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
	(in millions)				
Debt	$ 4,950	$ 150	$ 1,200	$ 600	$ 3,000
Interest (1)	3,021	200	379	347	2,095
Operating leases (2)	519	152	218	97	52
Purchase obligations (3)	429	226	188	15	—
Future policy benefits payable and other long-term liabilities (4)	3,396	91	482	208	2,615
Total	$ 12,315	$ 819	$ 2,467	$ 1,267	$ 7,762

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

Off-Balance Sheet Arrangements

As of December 31, 2017, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Other

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. On February 16, 2017, under the terms of the Merger Agreement, we received a breakup fee of $1 billion.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies primarily related to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2017	Percentage of Total	December 31, 2016	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,154	67.6%	$ 3,422	75.0%
Reported claims in process	614	13.1%	654	14.3%
Other benefits payable	900	19.3%	487	10.7%
Total benefits payable	$ 4,668	100.0%	$ 4,563	100.0%

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. For further discussion of our reserving methodology, including our use of completion and claims per member per month trend factors to estimate IBNR, refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2017 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.60%	$(182)	(2.75)%	$(287)
0.50%	$(152)	(2.50)%	$(261)
0.40%	$(121)	(2.25)%	$(235)
0.30%	$(91)	(2.00)%	$(209)
0.20%	$(61)	(1.75)%	$(183)
0.10%	$(30)	(1.50)%	$(157)
—%	$—	(1.25)%	$(131)

(a) Reflects estimated potential changes in benefits payable at December 31, 2017 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2017 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail, Group and Specialty, and Individual Commercial segment tables including information about incurred and paid claims development as of December 31, 2017, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2017	2016	2015
		(in millions)	
Balances at January 1	$ 4,563	$ 4,976	$ 4,475
Less: Premium deficiency reserve	—	(176)	—
Less: Reinsurance recoverables	(76)	(85)	(78)
Balances at January 1, net	4,487	4,715	4,397
Incurred related to:			
Current year	44,001	45,318	44,397
Prior years	(483)	(582)	(236)
Total incurred	43,518	44,736	44,161
Paid related to:			
Current year	(39,496)	(40,852)	(39,802)
Prior years	(3,911)	(4,112)	(4,041)
Total paid	(43,407)	(44,964)	(43,843)
Premium deficiency reserve	—	—	176
Reinsurance recoverable	70	76	85
Balances at December 31	$ 4,668	$ 4,563	$ 4,976

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2017		2016		2015	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (279)	(2.6)%	$ (316)	(2.9)%	$ (145)	(1.5)%
Completion factors	(204)	0.7 %	(266)	0.9 %	(91)	0.4 %
Total	$ (483)		$ (582)		$ (236)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017, $582 million in 2016, and $236 million in 2015. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2017, 2016, and 2015.

	Favorable Medical Claims Reserve Development			Change	
	2017	2016	2015	2017	2016
	(in millions)				
Retail Segment	$ (386)	$ (429)	$ (248)	$ 43	$ (181)
Group and Specialty Segment	(40)	(46)	(7)	6	(39)
Individual Commercial Segment	(56)	(106)	20	50	(126)
Other Businesses	(1)	(1)	(1)	—	—
Total	$ (483)	$ (582)	$ (236)	$ 99	$ (346)

The favorable medical claims reserve development for 2017, 2016, and 2015 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2017 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Premium deficiency reserve for short-duration policies	$ —	$ (176)	$ 176
Military services	—	8	12
Future policy benefits	(22)	439	(80)
Total	$ (22)	$ 271	$ 108

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Military services benefits expense for each year in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG acquisition as more fully described below and in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Certain health policies sold to individuals prior to 2014 (the first year plans compliant with the Health Care Reform Law were effective) are accounted for as long-duration as more fully described below. Benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

Future policy benefits payable of $2.9 billion and $2.8 billion at December 31, 2017 and 2016, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $2.3 billion at December 31, 2017 and $2.2 billion at December 31, 2016 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 29,800 policies remain in force as of December 31, 2017. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was a $168 million additional liability at December 31, 2017 and $77 million additional liability at December 31, 2016. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. A prolonged period during which interest rates remain at levels lower than those anticipated in our reserving would result in shortfalls in investment income on assets supporting our obligation under long term care policies because the long duration of the policy obligations exceeds the duration of the supporting investment assets. Further, we monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, future material adjustments to reserves could be required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets.

For our closed block of long-term care policies, actuarial assumptions used to estimate reserves are inherently uncertain due to the potential changes in trends in mortality, morbidity, persistency and interest rates as well as premium rate increases. As a result, our long term care reserves may be subject to material increases if these trends develop adversely to our expectations. The estimated increase in reserves and additional benefit expense from hypothetically modeling adverse variations in our actuarial assumptions, in the aggregate, could be up to $250 million, net of reinsurance. Although such hypothetical revisions are not currently appropriate, we believe they could occur based on past variances in experience and our expectation of the ranges of future experience that could reasonably occur, and any such revision could be material. Generally accepted accounting principles do not allow us to unlock our assumptions for favorable items.

In addition, future policy benefits payable includes amounts of $199 million at December 31, 2017, $201 million at December 31, 2016, and $205 million at December 31, 2015 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Our commercial contracts establish rates on a per employee basis for each month of coverage based on the type of coverage purchased (single to family coverage options). Our Medicare and Medicaid contracts also establish monthly rates per member. However, our Medicare contracts also have additional provisions as outlined in the following separate section.

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer's enrollment and individuals that ultimately may fail to pay, and for estimated rebates under the minimum benefit ratios required under the Health Care Reform Law. Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on

available data and historical trends. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in the current period's revenue.

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from for our Medicare and commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Investment Securities

Investment securities totaled $12.3 billion, or 45% of total assets at December 31, 2017, and $9.8 billion, or 39% of total assets at December 31, 2016. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2017 and 2016. The fair value of debt securities were as follows at December 31, 2017 and 2016:

	December 31, 2017	Percentage of Total	December 31, 2016	Percentage of Total
			(dollars in millions)	
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 531	4.3%	$ 786	8.0%
Mortgage-backed securities	1,610	13.1%	1,637	16.7%
Tax-exempt municipal securities	3,889	31.6%	3,305	33.7%
Mortgage-backed securities:				
Residential	26	0.2%	9	0.1%
Commercial	456	3.7%	304	3.1%
Asset-backed securities	408	3.3%	160	1.7%
Corporate debt securities	5,382	43.8%	3,597	36.7%
Total debt securities	$ 12,302	100.0%	$ 9,798	100.0%

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2017. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $222 million at December 31, 2017 and $276 million at December 31, 2016. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.8 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.9 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 9%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $94 million and $132 million at December 31, 2017 and 2016, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was less than $1 million at December 31, 2017 and December 31, 2016. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial services industry was 30% at December 31, 2017 and 23% at December 31, 2016.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2017:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2017						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 273	$ (1)	$ 130	$ (1)	$ 403	$ (2)
Mortgage-backed securities	581	(2)	672	(17)	1,253	(19)
Tax-exempt municipal securities	1,590	(16)	661	(12)	2,251	(28)
Mortgage-backed securities:						
Residential	20	—	3	—	23	—
Commercial	131	(1)	28	(1)	159	(2)
Asset-backed securities	107	—	10	—	117	—
Corporate debt securities	1,297	(10)	804	(27)	2,101	(37)
Total debt securities	$ 3,999	$ (30)	$ 2,308	$ (58)	$ 6,307	$ (88)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is other than temporary requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2017 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2017.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2017 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2017, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2017. There were no material other-than-temporary impairments in 2017, 2016, or 2015.

Goodwill and Long-lived Assets

At December 31, 2017, goodwill and other long-lived assets represented 19% of total assets and 52% of total stockholders' equity, compared to 20% and 47%, respectively, at December 31, 2016.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2017 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our provider services reporting unit in our Healthcare Services segment. The provider services reporting unit, with $590 million of goodwill, would decline to less than 10% margin after factoring in a 100 basis point increase in the discount rate.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2017 or December 31, 2016.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2017. Our net unrealized position increased $226 million from a net unrealized loss position of $28 million at December 31, 2016 to a net unrealized gain position of $198 million at December 31, 2017. At December 31, 2017, we had gross unrealized losses of $88 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2017. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.1 years as of December 31, 2017 and 4.4 years as of December 31, 2016. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $697 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2017 and 2016. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points once, and have changed by less than 100 basis points eight times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2017						
Investment income (a)	$ (87)	$ (83)	$ (67)	$ 67	$ 134	$ 202
Interest expense (b)	2	2	2	(2)	(3)	(5)
Pretax	$ (85)	$ (81)	$ (65)	$ 65	$ 131	$ 197
As of December 31, 2016						
Investment income (a)	$ (49)	$ (44)	$ (36)	$ 53	$ 107	$ 162
Interest expense (b)	3	3	3	(2)	(5)	(9)
Pretax	$ (46)	$ (41)	$ (33)	$ 51	$ 102	$ 153

(a) As of December 31, 2017 and 2016, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2017 or December 31, 2016. There was $150 million outstanding under our commercial paper program at December 31, 2017. As of December 31, 2017, our interest rate under our commercial paper program was less than 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2017	2016
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,042	$ 3,877
Investment securities	9,557	7,595
Receivables, less allowance for doubtful accounts of $96 in 2017 and $118 in 2016	854	1,280
Other current assets	2,949	3,438
Total current assets	17,402	16,190
Property and equipment, net	1,584	1,505
Long-term investment securities	2,745	2,203
Goodwill	3,281	3,272
Other long-term assets	2,166	2,226
Total assets	$ 27,178	$ 25,396
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,668	$ 4,563
Trade accounts payable and accrued expenses	4,069	2,467
Book overdraft	141	212
Unearned revenues	378	280
Short-term borrowings	150	300
Total current liabilities	9,406	7,822
Long-term debt	4,770	3,792
Future policy benefits payable	2,923	2,834
Other long-term liabilities	237	263
Total liabilities	17,336	14,711
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,572,458 shares issued at December 31, 2017 and 198,495,007 shares issued at December 31, 2016	33	33
Capital in excess of par value	2,445	2,562
Retained earnings	13,670	11,454
Accumulated other comprehensive income (loss)	19	(66)
Treasury stock, at cost, 60,893,762 shares at December 31, 2017 and 49,189,811 shares at December 31, 2016	(6,325)	(3,298)
Total stockholders' equity	9,842	10,685
Total liabilities and stockholders' equity	$ 27,178	$ 25,396

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2017	2016	2015
	(in millions, except per share results)		
Revenues:			
Premiums	$ 52,380	$ 53,021	$ 52,409
Services	982	969	1,406
Investment income	405	389	474
Total revenues	53,767	54,379	54,289
Operating expenses:			
Benefits	43,496	45,007	44,269
Operating costs	6,567	7,173	7,295
Merger termination fee and related costs, net	(936)	104	23
Depreciation and amortization	378	354	355
Total operating expenses	49,505	52,638	51,942
Income from operations	4,262	1,741	2,347
Gain on sale of business	—	—	270
Interest expense	242	189	186
Income before income taxes	4,020	1,552	2,431
Provision for income taxes	1,572	938	1,155
Net income	$ 2,448	$ 614	$ 1,276
Basic earnings per common share	$ 16.94	$ 4.11	$ 8.54
Diluted earnings per common share	$ 16.81	$ 4.07	$ 8.44

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Net income	$ 2,448	$ 614	$ 1,276
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	149	(101)	(114)
Effect of income taxes	(55)	38	42
Total change in unrealized investment gains/losses, net of tax	94	(63)	(72)
Reclassification adjustment for net realized gains included in investment income	(14)	(96)	(146)
Effect of income taxes	5	35	53
Total reclassification adjustment, net of tax	(9)	(61)	(93)
Other comprehensive income (loss), net of tax	85	(124)	(165)
Comprehensive income	$ 2,533	$ 490	$ 1,111

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2015	197,952	$ 33	$ 2,330	$ 9,916	$ 223	$ (2,856)	$ 9,646
Net income				1,276			1,276
Other comprehensive loss					(165)		(165)
Common stock repurchases			100			(485)	(385)
Dividends and dividend equivalents			—	(175)			(175)
Stock-based compensation			109				109
Restricted stock unit vesting	159	—	(49)			49	—
Stock option exercises	261	—	23				23
Stock option and restricted stock tax benefit			17				17
Balances, December 31, 2015	198,372	33	2,530	11,017	58	(3,292)	10,346
Net income				614			614
Other comprehensive loss					(124)		(124)
Common stock repurchases			—			(104)	(104)
Dividends and dividend equivalents			—	(177)			(177)
Stock-based compensation			115				115
Restricted stock unit vesting	13	—	(98)			98	—
Stock option exercises	110	—	13				13
Stock option and restricted stock tax benefit			2				2
Balances, December 31, 2016	198,495	33	2,562	11,454	(66)	(3,298)	10,685
Net income				2,448			2,448
Other comprehensive income					85		85
Common stock repurchases			(200)			(3,165)	(3,365)
Dividends and dividend equivalents			—	(232)			(232)
Stock-based compensation			157				157
Restricted stock unit vesting	—	—	(138)			138	—
Stock option exercises	77	—	64				64
Balances, December 31, 2017	198,572	$ 33	$ 2,445	$ 13,670	$ 19	$ (6,325)	$ 9,842

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Cash flows from operating activities			
Net income	$ 2,448	$ 614	$ 1,276
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of business	—	—	(270)
Depreciation	410	388	354
Amortization	75	77	93
Stock-based compensation	157	115	109
Net realized capital gains	(14)	(96)	(146)
Provision (benefit) for deferred income taxes	132	(71)	(2)
Provision for doubtful accounts	20	39	61
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	406	(158)	(180)
Other assets	(582)	426	(872)
Benefits payable	105	(413)	501
Other liabilities	641	937	(129)
Unearned revenues	98	(84)	3
Other	155	162	70
Net cash provided by operating activities	4,051	1,936	868
Cash flows from investing activities			
Acquisitions, net of cash acquired	(31)	(7)	(38)
Proceeds from sale of business	—	—	1,061
Purchases of property and equipment	(526)	(527)	(523)
Proceeds from sales of property and equipment	2	—	1
Purchases of investment securities	(6,265)	(6,566)	(6,739)
Maturities of investment securities	1,111	1,426	1,065
Proceeds from sales of investment securities	2,768	4,312	5,493
Net cash (used in) provided by investing activities	(2,941)	(1,362)	320
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	1,823	1,093	(296)
Proceeds from issuance of senior notes, net	1,779	—	—
(Repayments) proceeds from issuance of commercial paper, net	(153)	(2)	298
Repayment of long-term debt	(800)	—	—
Common stock repurchases	(3,365)	(104)	(385)
Dividends paid	(220)	(177)	(172)
Excess tax benefit from stock-based compensation	—	—	15
Change in book overdraft	(71)	(89)	(33)
Proceeds from stock option exercises and other, net	62	11	21
Net cash (used in) provided by financing activities	(945)	732	(552)
Increase in cash and cash equivalents	165	1,306	636
Cash and cash equivalents at beginning of year	3,877	2,571	1,935
Cash and cash equivalents at end of year	$ 4,042	$ 3,877	$ 2,571
Supplemental cash flow disclosures:			
Interest payments	$ 216	$ 185	$ 187
Income tax payments, net	$ 1,498	$ 916	$ 1,179
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 31	$ 7	$ 38
Less: Fair value of liabilities assumed	—	—	—

Cash paid for acquired businesses, net of cash acquired	$ 31	$ 7	$ 38

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 79% of our total premiums and services revenue from contracts with the federal government in 2017, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidated the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, future policy benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

Acquisition of a 40% Minority Interest in Kindred's Homecare Business

On December 19, 2017, we announced that we have entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division (Kindred at Home) of Kindred Healthcare, Inc. (Kindred)(NYSE: KND), the nation's largest home health provider and second largest hospice operator, for estimated cash consideration of approximately $800 million, including our share of transaction and related expenses, to facilitate a complete separation from the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital company). TPG Capital (TPG) and Welsh, Carson, Anderson & Stowe (WCAS), two private equity funds, collectively, the Sponsors, along with us are jointly creating a consortium to purchase all of the outstanding and issued securities of Kindred Healthcare, Inc. Immediately following the closing of that transaction, Kindred at Home and the Specialty Hospital company will be separated, with the result being that the Specialty Hospital Company will be owned by the Sponsors and Kindred at Home will be owned by a joint venture owned by the Sponsors and us. We will own 40% of Kindred at Home, with the remaining 60% owned by a new entity owned by TPG and WCAS.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

At the closing of the transaction, we will enter a shareholders agreement with the Sponsors that will provide for certain rights and obligations of each party concerning the newly formed joint venture that will own Kindred at Home. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture starting at the end of year three and ending at the end of year four following the closing. Consideration upon exercise of the put option per the agreement would be valued at an exit multiple of 10.5 times the preceding twelve months earnings before interest, income taxes, depreciation and amortization, or EBITDA, subject to certain adjustments. In addition, the multiple is subject to adjustment up to 11.5 times EBITDA based on the achievement of certain pre-defined value-based outcomes tied to clinical metrics. The 11.5 times EBITDA exit multiple is comparable to the valuation of our acquired interest in Kindred at Home. Finally, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning at the end of year four and ending at the end of year five following the closing for cash consideration using the same valuation methodology applicable to the previously discussed put option consideration.

The above transactions, which are anticipated to close in the summer of 2018, are subject to customary state and federal regulatory approvals, including approval by the stockholders of Kindred and the expiration of the waiting period under the Hart-Scott-Rodino Antitrust Improvement Act of 1976, as amended, as well as other customary closing conditions. We expect to fund the transaction through the use of parent company cash and will account for the minority investment under the equity method. The pending transaction did not have a material impact to earnings in 2017.

Sale of Closed Block of Commercial Long-Term Care Insurance Business

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care insurance policies. Based on the terms of the definitive agreement we expect to record a net loss associated with the sale of KMG of approximately $365 million. The estimated loss includes a pretax loss of approximately $780 million, offset by the expected tax benefit of approximately $415 million. We will fund the transaction with approximately $203 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $150 million of statutory capital with the sale, which together should be more than offset by the estimated $415 million cash savings associated with the expected tax treatment of the sale. The KMG transaction is anticipated to close by the third quarter of 2018 subject to customary closing conditions, including South Carolina Department of Insurance approval. There can be no assurance we will obtain regulatory approvals needed to sell the business or do so under terms acceptable to us.

Workforce Optimization

During 2017, we initiated a voluntary early retirement program and an involuntary workforce reduction program. These programs impacted approximately 3,600 associates, or 7.8% of our workforce. As a result, we recorded charges of $148 million, or $0.64 per diluted common share. These charges are included with operating costs in the consolidated statements of income for the year ended December 31, 2017 and are included at the corporate level in the segment financial information in Note 17. Payments under these programs are made upon termination during the early retirement or severance pay period, beginning in the first quarter of 2018. We expect this liability to be primarily paid within the next 12 months and classified it as a current liability, included in our consolidated balance sheet in the trade accounts payable and accrued expenses line.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as

amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

On July 21, 2016, the U.S. Department of Justice, or DOJ, and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. On February 16, 2017, under the terms of the Merger Agreement, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned Merger termination fee and related costs, net. Prior period Merger related transaction costs, previously included in operating costs, have been reclassified to conform to the 2017 presentation.

Business Segment Reclassifications

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation. See Note 17 for recast segment financial information.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges coupled with three premium stabilization programs, as described more fully below.

The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurer fee, but the fee is scheduled to resume in calendar year 2020. See Note 7 for detail regarding amounts paid for the annual health insurer fee.

The Health Care Reform Law also established risk spreading premium stabilization programs effective January 1, 2014, with an annual open enrollment period. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

13% of our total premiums and services revenue for the year ended December 31, 2017, a subset of which is subject to these programs. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Effective January 1, 2018, we have exited our Individual Commercial medical business. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law. We refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits.

The temporary risk corridor program applied to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including our small group health plans, were not subject to the risk corridor program. The risk corridor provisions were intended to limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to us or require us to refund HHS a portion of the premiums we received.

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, and ceased recognizing revenues under the risk corridor program as discussed further in Note 7.

The transitional reinsurance program required us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the Health Care Reform Law in the individual commercial market were eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we accounted for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in our consolidated statements of income. We accounted for contributions made by individual commercial plans compliant with the Health Care Reform Law, which were subject to recoveries, as ceded premiums (a reduction of premiums) and similarly we accounted for any recoveries as ceded benefits (a reduction of benefits expense) in our consolidated statements of income.

See Note 7 for detail regarding amounts recorded to the consolidated balance sheets related to the 3Rs.

In addition to the provisions discussed above, beginning in 2014, HHS paid us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. These cost subsidy payments ceased effective October 2017. We accounted for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We did not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity was accumulated at the state and legal entity level and recorded in our consolidated balance sheet in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the coverage year. For 2017, payments to HHS associated with cost sharing subsidies for which we did not assume risk were approximately $76 million, exceeding receipts of $32 million by $44 million. For 2016, payments to HHS associated with cost sharing subsidies for which we did not assume risk were approximately $373 million, exceeding receipts of $345 million by $28 million. For 2015, receipts from HHS associated with cost sharing subsidies for which we did not assume risk were approximately $478 million, exceeding payments of $409 million by $69 million.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets. Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss,

only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions. Individual polices are subject to the requirements of the Health Care Reform Law as discussed previously.

Premiums Revenue

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership and changes in risk corridor estimates are recognized when the amounts become determinable and the collectibility is reasonably assured.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the individual, small group, and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Medicare Advantage products are also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2017, subsidy and discount reimbursements of $12.1 billion exceeded payments of $10.2 billion by $1.9 billion. For 2016, subsidy and discount reimbursements of $11.1 billion exceeded payments of $10.0 billion by $1.1 billion. For 2015, subsidy and discount payments of $8.9 billion exceeded reimbursements of $8.6 billion by $361 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 6 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to employer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectibility of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

Under our TRICARE contracts with the Department of Defense we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under our contracts net of estimated health care costs similar to an administrative services fee only agreement. Our contracts include fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2017, health care cost reimbursements and payments were each approximately $3.4 billion, with reimbursements exceeding payments by $11 million for the year. For 2016, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $25 million for the year. For 2015, health care cost reimbursements and payments were each approximately $3.3 billion with payments exceeding reimbursements by $4 million for the year.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 6, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.2 billion at December 31, 2017 and $889 million at December 31, 2016.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Life insurance, annuities, and certain health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As

a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model and accordingly policy acquisition costs are expensed as incurred because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the recognition of previously deferred acquisition costs.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 5 years for computer software, and 10 to 20 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and other intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Goodwill and Other Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

As discussed further below, we early adopted the Financial Accounting Standards Board, or FASB, issued guidance simplifying the accounting for goodwill impairment. We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2017, 2016, and 2015 did not result in an impairment loss.

Other intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Other intangible assets are amortized over the useful life, based upon the pattern of future cash flows attributable to the asset. This sometimes results in an accelerated method of amortization for customer contracts because the asset tends to dissipate at a more rapid rate in earlier periods. Other than customer contracts, other intangible assets generally are amortized using the straight-line method. We review other finite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well

as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent two months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent two months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of

each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, and epidemics also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In the fourth quarter of 2015, we recognized a premium deficiency reserve of $176 million for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year and recorded a change in estimate of $208 million in the second quarter of 2016 associated with the 2016 coverage year as discussed in more detail in Note 7. As of December 31, 2016 and December 31, 2017, we had no remaining premium deficiency reserve.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on industry actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. During 2016, we recorded a loss for a premium deficiency as discussed further in Note 18.

We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed previously, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the release of reserves for future policy benefits.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us beginning in 2018 as well as a call option that would allow us to purchase the controlling interest beginning in 2021. Accordingly, we recorded the effects of the put and call option at fair value. Changes in the fair values during the years ended December 31, 2017, 2016, and 2015 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2017, 2016, or 2015.

Related Party

As noted above, MCCI is a related party to Humana. In December 2015, we purchased a note receivable directly from a third-party bank syndicate related to the financing of MCCI's business and extended the exercise date of the put option to 2018 and the call option to 2021. The note receivable balance was $349 million and $314 million at December 31, 2017 and 2016, respectively, and was included with other long-term assets in our consolidated balance sheets. The note receivable bears interest at 10% annually, payable in quarterly installments, and matures in December 2020. We have also entered into a revolving note agreement providing a line of credit up to $55 million under which $18 million was outstanding at December 31, 2017, and we had no balance outstanding at December 31, 2016. The 2015 note purchase is included with purchases of investment securities in our consolidated statements of cash flows. The related interest income of $35 million and $30 million for 2017 and 2016, respectively, is included in investment income in our consolidated statements of income. The interest was accrued to the loan balance during 2017 and 2016 pursuant to the terms of the note. MCCI provides services to Humana Medicare Advantage members under capitation contracts with our health plans. Under these capitation agreements with Humana, MCCI assumes the financial risk associated with these Medicare Advantage members. We also have an outstanding advance to MCCI of approximately $3 million and $6 million at December 31, 2017 and 2016, respectively, with repayment terms tied to the performance

under the capitation agreements. We recognized benefits expense of approximately $1.1 billion in 2017, $1.1 billion in 2016 and $1.0 billion in 2015 under these capitation agreements with MCCI.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. However, prior to July 2, 2015, for awards granted to retirement eligible employees, compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. For awards granted on or after July 2, 2015 to retirement eligible employees, we recognize expense on a straight-line basis over the service period (the vesting period). We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model. Prior to 2016 we reported certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. In 2016, we prospectively applied the provisions of new guidance issued by the FASB related to the presentation of windfall tax benefits as cash flows from operating activities which resulted in reclassifying $20 million of cash flows from financing activities to operating activities for the three months ended March 31, 2016. We estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period.

Additional detail regarding our stock-based compensation plans is included in Note 13.

Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares, or units, using the treasury stock method.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally

classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment advisor. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities, as well as auction rate securities, are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows. Auction rate securities are debt instruments with interest rates that reset through periodic short-term auctions. From time to time, liquidity issues in the credit markets have led to failed auctions. Given the liquidity issues, fair value could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In January 2017, the FASB issued guidance which simplifies the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. A goodwill impairment charge would be recognized if the carrying amount of a reporting unit exceeds the estimated fair value of the reporting unit. The new guidance is effective beginning with annual and interim periods in 2020, with early adoption permitted, and is to be applied prospectively. We early adopted this new guidance in the fourth quarter of 2017 and it did not have an impact on our results of operations, financial condition, or cash flows.

Accounting Pronouncements Effective in Future Periods

In March 2017, the FASB issued new guidance that amends the accounting for premium amortization on purchased callable debt securities by shortening the amortization period. This amended guidance requires the premium to be amortized to the earliest call date instead of maturity date. The new guidance is effective for us beginning with annual and interim periods in 2019. We do not expect adoption of this guidance will have a material impact on our results of operations, financial condition and cash flows.

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance is effective for us beginning January 1, 2020. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio consists of available-for-sale debt securities. We are currently evaluating the impact on our results of operations, financial condition, or cash flows.

In February 2016, the FASB issued new guidance related to accounting for leases which requires lessees to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). The new guidance is effective for us beginning with annual and interim periods in 2019, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We have begun the process of identifying the population of lease agreements and other arrangements that may contain embedded leases for purposes of adopting the new standard. While we expect to record significant leased assets and corresponding lease obligations based on our existing population of individual leases, we continue to evaluate the impact on our results of operations, financial position and cash flows.

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. Accordingly, our premiums revenue and investment income, collectively representing approximately 98% of our consolidated external revenues for 2017, are not included in the scope of the new guidance. We adopted the new standard effective January 1, 2018, as allowed, using the modified retrospective approach. As the majority of or revenues are not subject to the new guidance and the remaining revenues' accounting treatment did not materially differ from existing accounting treatment, the adoption of the new standard did not have a material impact on our consolidated results of operations, financial condition, cash flows, and disclosures.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS AND DIVESTITURES

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe, a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million which is reported as gain on sale of business in the accompanying consolidated statements of income for the year ended December 31, 2015. The accompanying consolidated statements of income include revenues related to Concentra of $411 million in 2015.

During 2017, 2016 and 2015, we acquired health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2017, 2016, and 2015 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2017 and 2016, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2017				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 532	$ 1	$ (2)	$ 531
Mortgage-backed securities	1,625	4	(19)	1,610
Tax-exempt municipal securities	3,884	33	(28)	3,889
Mortgage-backed securities:				
Residential	26	—	—	26
Commercial	455	3	(2)	456
Asset-backed securities	407	1	—	408
Corporate debt securities	5,175	244	(37)	5,382
Total debt securities	$ 12,104	$ 286	$ (88)	$ 12,302
December 31, 2016				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 800	$ 1	$ (15)	$ 786
Mortgage-backed securities	1,662	6	(31)	1,637
Tax-exempt municipal securities	3,358	15	(68)	3,305
Mortgage-backed securities:				
Residential	9	—	—	9
Commercial	307	1	(4)	304
Asset-backed securities	160	—	—	160
Corporate debt securities	3,530	145	(78)	3,597
Total debt securities	$ 9,826	$ 168	$ (196)	$ 9,798

Humana Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2017 and 2016, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2017						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 273	$ (1)	$ 130	$ (1)	$ 403	$ (2)
Mortgage-backed securities	581	(2)	672	(17)	1,253	(19)
Tax-exempt municipal securities	1,590	(16)	661	(12)	2,251	(28)
Mortgage-backed securities:						
Residential	20	—	3	—	23	—
Commercial	131	(1)	28	(1)	159	(2)
Asset-backed securities	107	—	10	—	117	—
Corporate debt securities	1,297	(10)	804	(27)	2,101	(37)
Total debt securities	$ 3,999	$ (30)	$ 2,308	$ (58)	$ 6,307	$ (88)
December 31, 2016						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 697	$ (15)	$ 3	$ —	$ 700	$ (15)
Mortgage-backed securities	1,528	(31)	3	—	1,531	(31)
Tax-exempt municipal securities	2,756	(67)	43	(1)	2,799	(68)
Mortgage-backed securities:						
Residential	—	—	4	—	4	—
Commercial	182	(3)	24	(1)	206	(4)
Asset-backed securities	51	—	63	—	114	—
Corporate debt securities	1,544	(71)	69	(7)	1,613	(78)
Total debt securities	$ 6,758	$ (187)	$ 209	$ (9)	$ 6,967	$ (196)

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2017. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2017, 6% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 49% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 51% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 9%. In addition, 2% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Residential mortgage back securities comprised approximately 93% of our agency mortgage-backed securities at December 31, 2017 and 99% at December 31, 2016.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2017 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2017.

The percentage of corporate securities associated with the financial services industry was 30% at December 31, 2017 and 23% at December 31, 2016.

Our unrealized loss from all securities was generated from approximately 900 positions out of a total of approximately 2,410 positions at December 31, 2017. All issuers of securities we own that were trading at an unrealized loss at December 31, 2017 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2017, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2017.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2017, 2016, and 2015:

	2017	2016	2015
		(in millions)	
Gross realized gains	$ 35	$ 120	$ 179
Gross realized losses	(21)	(24)	(33)
Net realized capital gains	$ 14	$ 96	$ 146

There were no material other-than-temporary impairments in 2017, 2016, or 2015.

The contractual maturities of debt securities available for sale at December 31, 2017, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 712	$ 711
Due after one year through five years	2,872	2,867
Due after five years through ten years	2,661	2,657
Due after ten years	3,346	3,567
Mortgage and asset-backed securities	2,513	2,500
Total debt securities	$ 12,104	$ 12,302

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2017 and 2016, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2017				
Cash equivalents	$ 4,564	$ 4,564	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	531	—	531	—
Mortgage-backed securities	1,610	—	1,610	—
Tax-exempt municipal securities	3,889	—	3,889	—
Mortgage-backed securities:				
Residential	26	—	26	—
Commercial	456	—	456	—
Asset-backed securities	408	—	408	—
Corporate debt securities	5,382	—	5,381	1
Total debt securities	12,302	—	12,301	1
Total invested assets	$ 16,866	$ 4,564	$ 12,301	$ 1
December 31, 2016				
Cash equivalents	$ 3,654	$ 3,654	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	786	—	786	—
Mortgage-backed securities	1,637	—	1,637	—
Tax-exempt municipal securities	3,305	—	3,302	3
Mortgage-backed securities:				
Residential	9	—	9	—
Commercial	304	—	304	—
Asset-backed securities	160	—	160	—
Corporate debt securities	3,597	—	3,593	4
Total debt securities	9,798	—	9,791	7
Total invested assets	$ 13,452	$ 3,654	$ 9,791	$ 7

There were no material transfers between Level 1 and Level 2 during 2017 or 2016.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our Level 3 assets had a fair value of $1 million at December 31, 2017, or less than 0.1% of our total invested assets. During the years ended December 31, 2017, 2016, and 2015, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2017			2016			2015		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$ 4	$ 3	$ 7	$ 6	$ 5	$ 11	$ 24	$ 8	$ 32
Total gains or losses:									
Realized in earnings	—	—	—	—	—	—	(1)	—	(1)
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	(3)	—	(3)	—	—	—	(17)	(3)	(20)
Settlements	—	(3)	(3)	(2)	(2)	(4)	—	—	—
Balance at December 31	$ 1	$ —	$ 1	$ 4	$ 3	$ 7	$ 6	$ 5	$ 11

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $4,770 million at December 31, 2017 and $3,792 million at December 31, 2016. The fair value of our long-term debt was $5,191 million at December 31, 2017 and $4,004 million at December 31, 2016. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for our commercial paper borrowings. There were outstanding commercial paper borrowings of $150 million outstanding at December 31, 2017, compared to $300 million outstanding at December 31, 2016.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisitions of certain health and wellness related businesses during 2017, 2016, and 2015. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2017, 2016, or 2015.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2017 and 2016. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2017		2016	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 4	$ 101	$ 8	$ 1,001
Trade accounts payable and accrued expenses	(255)	(1,085)	(158)	(128)
Net current (liability) asset	(251)	(984)	(150)	$ 873
Other long-term liabilities	(28)	—	—	—
Total net (liability) asset	$ (279)	$ (984)	$ (150)	$ 873

7. HEALTH CARE REFORM

We have exited our individual commercial medical business effective January 1, 2018. Operating results for our individual commercial medical business compliant with the Health Care Reform Law were challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 that we believed would improve the profitability of our individual commercial medical business in 2016. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results that included the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment in the fourth quarter of 2015 of the profitability of our individual commercial medical policies compliant with the Health Care Reform Law, we recorded in that quarter a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million in benefits payable in our consolidated balance sheet with a corresponding increase in benefits expense in our consolidated statement of income. In the second quarter of 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense in our consolidated statement of income. During 2016, $384 million current period losses were applied to the premium deficiency reserve liability for the 2016 coverage year. At December 31, 2017 and 2016, we had no premium deficiency reserve.

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2017, we collected approximately $39 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2017 and December 31, 2016.

	2017			2016		
	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
	(in millions)					
Prior Coverage Years						
Premiums receivable	$ —	$ —	$ —	$ 307	$ —	$ —
Other current assets	—	44	—	—	260	—
Trade accounts payable and accrued expenses	—	—	—	(117)	—	—
Net current asset	—	44	—	190	260	—
Other long-term assets	—	—	—	6	—	—
Total prior coverage years' net asset	—	44	—	196	260	—
Current Coverage Year						
Premiums receivable	62	—	—	—	—	—
Trade accounts payable and accrued expenses	(80)	—	—	—	—	—
Net current liability	(18)	—	—	—	—	—
Other long-term assets	5	—	—	—	—	—
Total prior coverage years' net liability	(13)	—	—	—	—	—
Total net (liability) asset	$ (13)	$ 44	$ —	$ 196	$ 260	$ —

Net collections under the 3Rs associated with prior coverage years were $440 million during 2017 and were $383 million during 2016. We expect to collect the remaining $44 million of reinsurance recoverables related to prior coverage years in 2018.

The annual health insurance industry fee was suspended for calendar year 2017, but has resumed for calendar year 2018. In 2016, we paid the federal government $916 million for the annual health insurance industry fee attributed to calendar year 2016, compared to $867 million in 2015, in accordance with the Health Care Reform Law. This fee is not deductible for tax purposes. The annual health insurance industry fee was also suspended for the calendar year 2019 and is scheduled to resume in calendar year 2020.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2017 and 2016.

	2017	2016
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	713	681
Equipment	824	750
Computer software	2,003	1,744
	3,560	3,195
Accumulated depreciation	(1,976)	(1,690)
Property and equipment, net	$ 1,584	$ 1,505

Depreciation expense was $410 million in 2017, $388 million in 2016, and $354 million in 2015, including amortization expense for capitalized internally developed and purchased software of $287 million in 2017, $255 million in 2016, and $220 million in 2015.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2017 segment reclassification as discussed in Note 1. Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2017 and 2016 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2016	$ 1,059	$ 261	$ 1,945	$ 3,265
Acquisitions	—	—	7	7
Balance at December 31, 2016	1,059	261	1,952	3,272
Acquisitions	—	—	9	9
Balance at December 31, 2017	$ 1,059	$ 261	$ 1,961	$ 3,281

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2017 and 2016.

	Weighted Average Life	2017			2016		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	9.8 years	$ 566	$ 401	$ 165	$ 566	$ 347	$ 219
Trade names and technology	8.2 years	104	84	20	104	69	35
Provider contracts	11.9 years	68	30	38	51	29	22
Noncompetes and other	8.1 years	32	29	3	32	28	4
Total other intangible assets	9.7 years	$ 770	$ 544	$ 226	$ 753	$ 473	$ 280

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Amortization expense for other intangible assets was approximately $75 million in 2017, $77 million in 2016, and $93 million in 2015. The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2018	$ 64
2019	54
2020	52
2021	19
2022	16

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

10. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Balances at January 1	$ 4,563	$ 4,976	$ 4,475
Less: Premium deficiency reserve	—	(176)	—
Less: Reinsurance recoverables	(76)	(85)	(78)
Balances at January 1, net	4,487	4,715	4,397
Incurred related to:			
Current year	44,001	45,318	44,397
Prior years	(483)	(582)	(236)
Total incurred	43,518	44,736	44,161
Paid related to:			
Current year	(39,496)	(40,852)	(39,802)
Prior years	(3,911)	(4,112)	(4,041)
Total paid	(43,407)	(44,964)	(43,843)
Premium deficiency reserve	—	—	176
Reinsurance recoverable	70	76	85
Balances at December 31	$ 4,668	$ 4,563	$ 4,976

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017, $582 million in 2016, and $236 million in 2015. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2017, 2016, and 2015.

	Favorable Medical Claims Reserve Development		
	2017	2016	2015
Retail Segment	$ (386)	$ (429)	$ (248)
Group and Specialty Segment	(40)	(46)	(7)
Individual Commercial Segment	(56)	(106)	20
Other Businesses	(1)	(1)	(1)
Total	$ (483)	$ (582)	$ (236)

The favorable medical claims reserve development for 2017, 2016, and 2015 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development in 2017 and 2016 primarily resulted from our Medicare Advantage and individual commercial medical businesses. The favorable prior period development in 2015 was impacted primarily by lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission

as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Premium deficiency reserve for short-duration policies	$ —	$ (176)	$ 176
Military services	—	8	12
Future policy benefits	(22)	439	(80)
Total	$ (22)	$ 271	$ 108

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7.

Military services benefits expense for each year in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG acquisition as more fully described in Note 18. Benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2017, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2015 and 2016 is presented as supplementary information.

Claims frequency is measured as medical fee-for-service claims for each service encounter with a unique provider identification number. Our claims frequency measure includes claims covered by deductibles as well as claims under capitated arrangements. Claim counts may vary based on product mix and the percentage of delegated capitation arrangements.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Balances at January 1	$ 3,506	$ 3,600	$ 3,428
Less: Reinsurance recoverables	(76)	(85)	(78)
Balances at January 1, net	3,430	3,515	3,350
Incurred related to:			
Current year	38,604	37,212	36,299
Prior years	(386)	(429)	(248)
Total incurred	38,218	36,783	36,051
Paid related to:			
Current year	(34,781)	(33,784)	(32,874)
Prior years	(2,974)	(3,084)	(3,012)
Total paid	(37,755)	(36,868)	(35,886)
Reinsurance recoverable	70	76	85
Balances at December 31	$ 3,963	$ 3,506	$ 3,600

At December 31, 2017, benefits payable for our Retail segment included IBNR of approximately $2.5 billion, primarily associated with claims incurred in 2017. The cumulative number of reported claims as of December 31, 2017 was approximately 97.8 million for claims incurred in 2017, 96.0 million for claims incurred in 2016, and 93.9 million for claims incurred in 2015.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2017, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
		(in millions)	
2015	$ 36,299	$ 35,928	$ 35,877
2016		37,212	36,891
2017			38,604
Total			$ 111,372

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$ 32,874	$ 35,918	$ 35,857
2016		33,784	36,841
2017			34,781
Total			$ 107,479
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 3,893

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Balances at January 1	$ 579	$ 616	$ 603
Less: Reinsurance recoverables	—	—	—
Balances at January 1, net	579	616	603
Incurred related to:			
Current year	5,403	5,271	5,377
Prior years	(40)	(46)	(7)
Total incurred	5,363	5,225	5,370
Paid related to:			
Current year	(4,843)	(4,700)	(4,774)
Prior years	(531)	(562)	(583)
Total paid	(5,374)	(5,262)	(5,357)
Balances at December 31	$ 568	$ 579	$ 616

At December 31, 2017, benefits payable for our Group and Specialty segment included IBNR of approximately $500 million, primarily associated with claims incurred in 2017. The cumulative number of reported claims as of December 31, 2017 was approximately 10.6 million for claims incurred in 2017, 12.8 million for claims incurred in 2016, and 13.4 million for claims incurred in 2015.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2017, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$ 5,377	$ 5,333	$ 5,333
2016		5,271	5,234
2017			5,403
Total			$ 15,970

	Cumulative Paid Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$ 4,774	$ 5,327	$ 5,333
2016		4,700	5,226
2017			4,843
Total			$ 15,402
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 568

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Individual Commercial Segment

Activity in benefits payable for our Individual Commercial segment, was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Balances at January 1	$ 454	$ 741	$ 424
Less: Premium deficiency reserve	—	(176)	—
Balances at January 1, net	454	565	424
Incurred related to:			
Current year	669	3,677	3,512
Prior years	(56)	(106)	20
Total incurred	613	3,571	3,532
Paid related to:			
Current year	(583)	(3,233)	(2,966)
Prior years	(383)	(449)	(425)
Total paid	(966)	(3,682)	(3,391)
Premium deficiency reserve	—	—	176
Balances at December 31	$ 101	$ 454	$ 741

At December 31, 2017, benefits payable for our Individual Commercial segment included IBNR of approximately $85 million, primarily associated with claims incurred in 2017. The cumulative number of reported claims as of December 31, 2017 was approximately 2.2 million for claims incurred in 2017, 9.5 million for claims incurred in 2016, and 11.0 million for claims incurred in 2015.

The following tables provide information about incurred and paid claims development for the Individual Commercial segment as of December 31, 2017, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
2015	$ 3,512	$ 3,412	$ 3,412
2016		3,677	3,621
2017			669
Total			$ 7,702

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$ 2,966	$ 3,400	$ 3,412
2016		3,233	3,606
2017			583
Total			$ 7,601
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 101

Reconciliation to Consolidated

The reconciliation of the net incurred and paid claims development tables to benefits payable in the consolidated statement of financial position is as follows:

	December 31, 2017
Net outstanding liabilities	
Retail	$ 3,893
Group and Specialty	568
Individual Commercial	101
Other insurance lines	36
Benefits payable, net of reinsurance	4,598
Reinsurance recoverable on unpaid claims	
Retail	70
Group and Specialty	—
Individual Commercial	—
Other insurance lines	—
Total reinsurance recoverable on unpaid claims	70
Total benefits payable, gross	$ 4,668

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Current provision:			
Federal	$ 1,324	$ 921	$ 1,067
States and Puerto Rico	116	88	90
Total current provision	1,440	1,009	1,157
Deferred expense (benefit)	132	(71)	(2)
Provision for income taxes	$ 1,572	$ 938	$ 1,155

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2017, 2016 and 2015 due to the following:

	2017	2016	2015
		(in millions)	
Income tax provision at federal statutory rate	$ 1,407	$ 543	$ 851
States, net of federal benefit, and Puerto Rico	80	41	44
Tax exempt investment income	(22)	(20)	(24)
Health insurer fee	—	336	314
Nondeductible executive compensation	36	30	18
Tax reform	133	—	—
Concentra sale	—	—	(67)
Other, net	(62)	8	19
Provision for income taxes	$ 1,572	$ 938	$ 1,155

The tax reform law enacted on December 22, 2017 (the "Tax Reform Law") reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018, and required a mandatory deemed repatriation of undistributed foreign earnings. The rate reduction required a remeasurement of our net deferred tax asset. These items resulted in an estimated increase in our 2017 tax provision of approximately $133 million, including approximately $10 million for the deemed repatriation tax imposed on the undistributed earnings of our Puerto Rico operations.

The provision for income taxes for 2017, 2016, and 2015 reflects a $36 million, $30 million, and $18 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Principal components of our net deferred tax balances at December 31, 2017 and 2016 were as follows:

	Assets (Liabilities)	
	2017	2016
	(in millions)	
Future policy benefits payable	$ 231	$ 355
Benefits payable	113	196
Compensation and other accrued expenses	138	153
Net operating loss carryforward	53	52
Deferred acquisition costs	48	72
Unearned revenues	12	18
Investment securities	—	12
Other	1	6
Total deferred income tax assets	596	864
Valuation allowance	(49)	(49)
Total deferred income tax assets, net of valuation allowance	547	815
Depreciable property and intangible assets	(237)	(363)
Prepaid expenses	(44)	(53)
Investment securities	(49)	—
Total deferred income tax liabilities	(330)	(416)
Total net deferred income tax assets	$ 217	$ 399

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position effective for us beginning with annual and interim periods in 2017. We elected to early adopt the guidance in 2015. All deferred tax liabilities and assets are classified as noncurrent in other long-term assets in our consolidated balance sheets at December 31, 2017 and 2016 to simplify their presentation.

At December 31, 2017, we had approximately $168 million of net operating losses to carry forward related to prior acquisitions and our Puerto Rico subsidiaries. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2018 through 2033. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $49 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2015 and prior years. Our 2016 tax return is in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2017 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2014. We are not aware of any material adjustments that may be proposed.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

12. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2017 and 2016:

	2017	2016
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 7.20% due June 15, 2018	$ —	$ 501
$300 million, 6.30% due August 1, 2018	—	304
$400 million, 2.625% due October 1, 2019	399	398
$400 million, 2.50% due December 15, 2020	397	—
$400 million, 2.90% due December 15, 2022	396	—
$600 million, 3.15% due December 1, 2022	595	595
$600 million, 3.85% due October 1, 2024	595	595
$600 million, 3.95% due March 15, 2027	594	—
$250 million, 8.15% due June 15, 2038	263	264
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	739
$400 million, 4.80% due March 15, 2047	396	—
Total long-term debt	$ 4,770	$ 3,792

Senior Notes

In December 2017, we issued $400 million of 2.50% senior notes due December 15, 2020 and $400 million of 2.90% senior notes due December 15, 2022. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of December 31, 2017, were $794 million. We used the net proceeds, together with available cash, to fund the redemption of our $300 million aggregate principal amount of 6.30% senior notes maturing in August 2018 and our $500 million aggregate principal amount of 7.20% senior notes maturing in June 2018 at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $829 million. We recognized a loss on extinguishment of debt of approximately $17 million in December 2017 for the redemption of these senior notes, which is included in interest expense in the consolidated statements of income.

In March 2017, we issued $600 million of 3.95% senior notes due March 15, 2027 and $400 million of 4.80% senior notes due March 15, 2047. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of March 31, 2017, were $991 million. The net proceeds from these issuances are being used for general corporate purposes.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes contain a change of control provision that may require us to purchase the notes under certain circumstances.

Credit Agreement

In May 2017 we amended and restated our previous 5-year $1.0 billion unsecured revolving credit agreement expiring July 2018 with a 5-year $2.0 billion unsecured revolving credit agreement which expires May 2022. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 91 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 9 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $9.2 billion at December 31, 2017 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $9.8 billion and an actual leverage ratio of 1.0:1, as measured in accordance with the credit agreement as of December 31, 2017. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the credit agreement to a maximum of $2.5 billion, through a $500 million incremental loan facility.

At December 31, 2017, we had no borrowings outstanding under the credit agreement and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2017, we had $2 billion of remaining borrowing capacity (which excludes the uncommitted $500 million incremental loan facility under the credit agreement), none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

We previously entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. On June 15, 2017, we increased the size of the commercial paper program to permit the issuance of the commercial notes with the aggregate face or principal amount outstanding under the program at any time not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2017 was $500 million, with $150 million outstanding at December 31, 2017, compared to $300 million outstanding at December 31, 2016.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $217 million in 2017, $196 million in 2016, and $188 million in 2015. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $248.07 on December 29, 2017, approximately 11% of the retirement and savings plan's assets were invested in our common stock, or approximately 2.0 million shares, representing 2% of the shares outstanding as of December 31, 2017. At December 31, 2017, approximately 2.4 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. For awards granted prior to July 2, 2015, our equity award agreements generally contain provisions whereby the awards automatically accelerate and vest upon change in control, including those granted to retirement-eligible participants described below. Awards granted on or after July 2, 2015 would generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants granted prior to July 2, 2015 generally will continue to fully vest on the originally scheduled vest date upon retirement from the Company. For stock awards of retirement-eligible employees granted on or after July 2, 2015, awards are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2017, 2016, and 2015:

	2017	2016	2015
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 145	$ 106	$ 99
Stock options	12	9	10
Total stock-based compensation expense	157	115	109
Tax benefit recognized	(32)	(20)	(26)
Stock-based compensation expense, net of tax	$ 125	$ 95	$ 83

Stock-based compensation expense for certain restricted stock in 2017 included a $29 million modification expense for certain awards.

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $68 million in 2017, $53 million in 2016, and $34 million in 2015. There was no capitalized stock-based compensation expense during these years.

At December 31, 2017, there were 14.6 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 5.4 million shares of common stock available for future grants assuming all stock options were granted or 2.4 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests three years from the date of grant. Restricted stock granted on or after July 2, 2015, generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $222.35 in 2017, $168.12 in 2016, and $165.26 in 2015. Activity for our restricted stock was as follows for the year ended December 31, 2017:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2016	2,492	$ 121.94
Granted	731	222.35
Vested	(1,386)	128.08
Forfeited	(184)	138.99
Nonvested restricted stock at December 31, 2017	1,653	$ 171.68

Approximately 19% of the nonvested restricted stock at December 31, 2017 included performance-based conditions.

The fair value of shares vested was $306 million during 2017, $253 million during 2016, and $153 million during 2015. Total compensation expense not yet recognized related to nonvested restricted stock was $133 million at December 31, 2017. We expect to recognize this compensation expense over a weighted-average period of approximately 1.8 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2017, 2016, and 2015 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2017	2016	2015
Weighted-average fair value at grant date	$ 49.81	$ 37.12	$ 36.91
Expected option life (years)	4.1 years	4.2 years	4.2 years
Expected volatility	27.1%	27.6%	27.4%
Risk-free interest rate at grant date	2.0%	1.1%	1.4%
Dividend yield	0.7%	0.7%	0.7%

When valuing employee stock options, we stratify the employee population into three homogeneous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2017:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2016	1,022	$ 143.04
Granted	358	218.06
Exercised	(492)	128.34
Forfeited	(25)	182.46
Options outstanding at December 31, 2017	863	$ 181.44
Options exercisable at December 31, 2017	182	$ 137.54

As of December 31, 2017, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $57 million, and a weighted-average remaining contractual term of 5.0 years. As of December 31, 2017, exercisable stock options had an aggregate intrinsic value of $20 million, and a weighted-average remaining contractual term of 3.5 years. The total intrinsic value of stock options exercised during 2017 was $44 million, compared with $18 million during 2016 and $28 million during 2015. Cash received from stock option exercises totaled $63 million in 2017, $14 million in 2016, and $23 million in 2015.

Total compensation expense not yet recognized related to nonvested options was $18 million at December 31, 2017. We expect to recognize this compensation expense over a weighted-average period of approximately 1.8 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 2,448	$ 614	$ 1,276
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	144,493	149,375	149,455
Dilutive effect of:			
Employee stock options	172	219	192
Restricted stock	920	1,323	1,495
Shares used to compute diluted earnings per common share	145,585	150,917	151,142
Basic earnings per common share	$ 16.94	$ 4.11	$ 8.54
Diluted earnings per common share	$ 16.81	$ 4.07	$ 8.44
Number of antidilutive stock options and restricted stock awards excluded from computation	539	748	415

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

15. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2015, 2016, and 2017 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2015	$1.14	$170
2016	$1.16	$172
2017	$1.49	$216

On November 2, 2017, the Board declared a cash dividend of $0.40 per share that was paid on January 26, 2018 to stockholders of record on December 29, 2017, for an aggregate amount of $55 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Repurchases

In September 2014, our Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with an authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, which expired on December 31, 2016. Under the share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. Pursuant to the Merger Agreement, after July 2, 2015, we were prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we suspended our share repurchase program.

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017.

On February 16, 2017, we entered into an accelerated share repurchase agreement, the February 2017 ASR, with Goldman, Sachs & Co. LLC, or Goldman Sachs, to repurchase $1.5 billion of our common stock as part of the $2.25 billion share repurchase program referred to above. On February 22, 2017, we made a payment of $1.5 billion to Goldman Sachs from available cash on hand and received an initial delivery of 5.83 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $1.2 billion increase in treasury stock, which reflected the value of the initial 5.83 million shares received upon initial settlement, and a $300 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the February 2017 ASR. Upon settlement of the February 2017 ASR on August 28, 2017, we received an additional 0.84 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the agreement of $224.81, bringing the total shares received under this program to 6.67 million. In addition, upon settlement we reclassified the $300 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock. Subsequent to settlement of the February 2017 ASR, we repurchased an additional 3.04 million shares in the open market, utilizing the remaining $750 million of the $2.25 billion authorization prior to expiration.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions, including pursuant to accelerated share repurchase agreements with investment banks, subject to certain regulatory restrictions on volume, pricing, and timing.

On December 21, 2017, we entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflects the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. The final number of shares that we may receive, or be required to remit, under the agreement will be determined based on the daily volume-weighted average share price of our common stock over the term of the agreement, less a discount and subject to adjustments pursuant to the terms and conditions of the agreement. Final settlement under the December 2017 ASR is expected to occur by the end of the first quarter of 2018. The agreement contains provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement may be accelerated or extended or the agreement may be terminated early by BofA or Humana, and various acknowledgements and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from BofA or we may be required to make a payment. If we are obligated to make payment, we may elect to satisfy such obligation in cash or shares of our common stock.

Our remaining repurchase authorization was approximately $2.0 billion as of February 16, 2018, excluding the $200 million pending final settlement of our December 22, 2017 ASR.

Excluding shares acquired in connection with employee stock plans as well as 0.36 million shares received in March 2015 upon final settlement of our 2014 accelerated share repurchase agreement, for which no cash was paid during the period, share repurchases were as follows during the years ended December 31, 2017, 2016 and 2015. Excluding shares acquired in connection with employee stock plans, there were no share repurchases in 2016.

		2017		2016		2015	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
			(in millions)				
September 2014	$ 2,000	—	$ —	—	$ —	1.85	$ 329
February 2017	2,250	9.71	2,250	—	—	—	—
December 2017	3,000	3.28	800	—	—	—	—
Total repurchases		12.99	$3,050	—	$ —	1.85	$ 329

In connection with employee stock plans, we acquired 0.5 million common shares for $115 million in 2017, 0.6 million common shares for $104 million in 2016, and 0.3 million common shares for $56 million in 2015.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $8.0 billion and $7.7 billion as of December 31, 2017 and 2016, respectively, which exceeded aggregate minimum regulatory requirements of $4.8 billion in both years. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2018 is approximately $1.1 billion in the aggregate. This compares to dividends that were paid to our parent company in 2017 of approximately $1.4 billion. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
		(in millions)	
Rent expense	$ 204	$ 179	$ 201
Sublease rental income	(33)	(26)	(25)
Net rent expense	$ 171	$ 153	$ 176

Future annual minimum payments due subsequent to December 31, 2017 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2018	$ 152	$ (14)	$ 138
2019	129	(13)	116
2020	89	(10)	79
2021	58	(8)	50
2022	39	(7)	32
Thereafter	52	(51)	1
Total	$ 519	$ (103)	$ 416

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $226 million in 2018, $150 million in 2019, $38 million in 2020, $8 million in 2021, and $7 million thereafter. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2017, we were not involved in any SPE transactions.

Guarantees and Indemnifications

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our military services subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our Medicare products, which accounted for approximately 78% of our total premiums and services revenue for the year ended December 31, 2017, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2018, and all of our product offerings filed with CMS for 2018 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition,

we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample will be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of Medicare FFS (we refer to the process of accounting for errors in FFS claims as the "FFS Adjuster"). This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013 in which two, five and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, these ordinary course reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

Our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2017, primarily consisted of the T3 TRICARE South Region contract. The 5-year T3 South Region contract expired on December 31, 2017. On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The T2017 East contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our state-based Medicaid business accounted for approximately 5% of our total premiums and services revenue for the year ended December 31, 2017. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services (LTSS), and in Illinois for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program. We previously had an Integrated Care Program Medicaid contract in Illinois, and a stand-alone dual eligible demonstration program in Virginia, both of which terminated at December 31, 2017.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Legal Proceedings and Certain Regulatory Matters

Florida Matters

On January 6, 2012, the Civil Division of the United States Attorney's Office for the Southern District of Florida advised us that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices. On May 1, 2014, the U.S. Attorney's Office filed a Notice of Non-Intervention in connection with a civil qui tam suit related to one of these matters captioned United States of America ex rel. Olivia Graves v. Plaza Medical Centers, et *al.*, and the Court ordered the complaint unsealed. All parties to the lawsuit and the United States have executed a settlement agreement to settle the plaintiff's claims for damages and penalties, with Humana paying an amount that is not material to our results of operations, and the court has closed the case.

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, separate from but related to the Plaza Medical matter, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, including the providers identified in the now settled Plaza Medical matter, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information

requests from the Department of Justice and the U.S. Attorney's Office. These matters are expected to result in additional qui tam litigation.

On January 19, 2016, an individual filed a qui tam suit captioned United States of America ex rel. Steven Scott v. Humana, Inc., in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by us in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by us under Medicare Part D, as compared to required benefit levels under applicable bid rules. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator can proceed, following notice from the U.S. Government that it is not intervening at this time. We take seriously our obligations to comply with applicable CMS requirements and actuarial best principles, and we intend to vigorously defend against these allegations.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid risk corridor payments as of December 31, 2017. We have fully recognized all liabilities due to the federal government that we have incurred under the risk corridor program, and have paid all amounts due to the federal government as required. There is no assurance that we will prevail in the lawsuit.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, general contractual matters, intellectual property matters, and challenges to subrogation practices. For example, a number of hospitals and other providers have asserted that, under their network provider contracts, we are not entitled to reduce Medicare Advantage payments to these providers in connection with changes in Medicare payment systems and in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration"). Those challenges have led and could lead to arbitration demands or other litigation. Also, under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extra contractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above and other ordinary course reviews of our internal business processes, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, investigations, internal reviews, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

17. SEGMENT INFORMATION

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation.

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health and voluntary insurance benefits, and financial protection products, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services

and capabilities to promote wellness and advance population health. The Individual Commercial segment consists of our individual commercial fully-insured medical health insurance benefits. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis, including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non-risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non-risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $13.5 billion in 2017, $13.4 billion in 2016, and $12.3 billion in 2015. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $107 million in 2017, $111 million in 2016, and $92 million in 2015.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail, Group and Specialty, and Individual Commercial segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our segment results were as follows for the years ended December 31, 2017, 2016, and 2015:

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2017							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 32,720	$ —	$ —	$ —	$ —	$ —	$ 32,720
Group Medicare Advantage	5,155	—	—	—	—	—	5,155
Medicare stand-alone PDP	3,702	—	—	—	—	—	3,702
Total Medicare	41,577	—	—	—	—	—	41,577
Fully-insured	478	5,462	—	947	—	—	6,887
Specialty	—	1,310	—	—	—	—	1,310
Medicaid and other	2,571	—	—	—	35	—	2,606
Total premiums	44,626	6,772	—	947	35	—	52,380
Services revenue:							
Provider	—	—	258	—	—	—	258
ASO and other	10	626	—	—	8	—	644
Pharmacy	—	—	80	—	—	—	80
Total services revenue	10	626	338	—	8	—	982
Total revenues—external customers	44,636	7,398	338	947	43	—	53,362
Intersegment revenues							
Services	—	20	17,293	—	—	(17,313)	—
Products	—	—	6,292	—	—	(6,292)	—
Total intersegment revenues	—	20	23,585	—	—	(23,605)	—
Investment income	90	31	35	4	87	158	405
Total revenues	44,726	7,449	23,958	951	130	(23,447)	53,767
Operating expenses:							
Benefits	38,218	5,363	—	544	131	(760)	43,496
Operating costs	4,292	1,590	22,848	201	12	(22,376)	6,567
Merger termination fee and related costs, net	—	—	—	—	—	(936)	(936)
Depreciation and amortization	238	84	143	13	—	(100)	378
Total operating expenses	42,748	7,037	22,991	758	143	(24,172)	49,505
Income (loss) from operations	1,978	412	967	193	(13)	725	4,262
Interest expense	—	—	—	—	—	242	242
Income (loss) before income taxes	$ 1,978	$ 412	$ 967	$ 193	$ (13)	$ 483	$ 4,020

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 79% for 2017, compared to 75% for 2016, and 73% for 2015.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2016							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 31,863	$ —	$ —	$ —	$ —	$ —	$ 31,863
Group Medicare Advantage	4,283	—	—	—	—	—	4,283
Medicare stand-alone PDP	4,009	—	—	—	—	—	4,009
Total Medicare	40,155	—	—	—	—	—	40,155
Fully-insured	428	5,405	—	3,064	—	—	8,897
Specialty	—	1,279	—	—	—	—	1,279
Medicaid and other	2,640	12	—	—	38	—	2,690
Total premiums	43,223	6,696	—	3,064	38	—	53,021
Services revenue:							
Provider	—	—	278	—	—	—	278
ASO and other	6	643	1	—	10	—	660
Pharmacy	—	—	31	—	—	—	31
Total services revenue	6	643	310	—	10	—	969
Total revenues—external customers	43,229	7,339	310	3,064	48	—	53,990
Intersegment revenues							
Services	—	22	18,979	—	—	(19,001)	—
Products	—	—	5,993	—	—	(5,993)	—
Total intersegment revenues	—	22	24,972	—	—	(24,994)	—
Investment income	90	25	30	5	66	173	389
Total revenues	43,319	7,386	25,312	3,069	114	(24,821)	54,379
Operating expenses:							
Benefits	36,783	5,233	—	3,301	617	(927)	45,007
Operating costs	4,650	1,727	24,073	601	16	(23,894)	7,173
Merger termination fee and related costs, net	—	—	—	—	—	104	104
Depreciation and amortization	196	82	143	36	1	(104)	354
Total operating expenses	41,629	7,042	24,216	3,938	634	(24,821)	52,638
Income (loss) from operations	1,690	344	1,096	(869)	(520)	—	1,741
Interest expense	—	—	—	—	—	189	189
Income (loss) before income taxes	$ 1,690	$ 344	$ 1,096	$ (869)	$ (520)	$ (189)	$ 1,552

Premiums revenue for our Individual Commercial segment for 2016 includes a reduction of $583 million associated with the write-off of commercial risk corridor receivables as discussed more fully in Note 7.

Benefits expense for Other Businesses for 2016 includes $505 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2015							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 29,526	$ —	$ —	$ —	$ —	$ —	$ 29,526
Group Medicare Advantage	5,588	—	—	—	—	—	5,588
Medicare stand-alone PDP	3,846	—	—	—	—	—	3,846
Total Medicare	38,960	—	—	—	—	—	38,960
Fully-insured	304	5,493	—	3,939	—	—	9,736
Specialty	—	1,316	—	—	—	—	1,316
Medicaid and other	2,341	21	—	—	35	—	2,397
Total premiums	41,605	6,830	—	3,939	35	—	52,409
Services revenue:							
Provider	—	—	695	—	—	—	695
ASO and other	8	658	1	—	14	—	681
Pharmacy	—	—	30	—	—	—	30
Total services revenue	8	658	726	—	14	—	1,406
Total revenues—external customers	41,613	7,488	726	3,939	49	—	53,815
Intersegment revenues							
Services	—	20	18,127	—	—	(18,147)	—
Products	—	—	4,923	—	—	(4,923)	—
Total intersegment revenues	—	20	23,050	—	—	(23,070)	—
Investment income	122	34	—	4	76	238	474
Total revenues	41,735	7,542	23,776	3,943	125	(22,832)	54,289
Operating expenses:							
Benefits	36,052	5,382	—	3,589	87	(841)	44,269
Operating costs	4,267	1,755	22,598	756	14	(22,095)	7,295
Merger termination fee and related costs, net	—	—	—	—	—	23	23
Depreciation and amortization	157	84	156	31	—	(73)	355
Total operating expenses	40,476	7,221	22,754	4,376	101	(22,986)	51,942
Income (loss) from operations	1,259	321	1,022	(433)	24	154	2,347
Gain on sale of business	—	—	—	—	—	270	270
Interest expense	—	—	—	—	—	186	186
Income (loss) before income taxes	$ 1,259	$ 321	$ 1,022	$ (433)	$ 24	$ 238	$ 2,431

Benefits expense for the Individual Commercial segment for 2015 includes $176 million for a provision for probable future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year as discussed more fully in Note 7.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for less than 1% of our consolidated premiums and services revenue for the year ended December 31, 2017. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). As discussed in Note 2, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model because premiums received in the current year are intended to pay anticipated benefits in that year.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2017 and 2016.

	2017		2016	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 103	$ —	$ 119	$ —
Trade accounts payable and accrued expenses	—	(56)	—	(62)
Long-term liabilities	—	(2,923)	—	(2,834)
Total asset (liability)	$ 103	$ (2,979)	$ 119	$ (2,896)

In addition, future policy benefits payable include amounts of $199 million at December 31, 2017 and $201 million at December 31, 2016 which are subject to 100% coinsurance agreements as more fully described in Note 19.

Benefit expense reflects a net reduction of $22 million in 2017, a net increase of $439 million in 2016 and a net reduction of $80 million in 2015. All three years include the effect of the release of reserves as Individual Commercial medical members transitioned to plans compliant with the Health Care Reform Law. In addition, 2016 reflects the net change of $505 million associated with our closed block of long-term care insurance policies discussed further below. Amortization of deferred acquisition costs included in operating costs was $71 million in 2017, $67 million in 2016, and $63 million in 2015, which includes the effect of accelerating deferred acquisition amortization costs of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

Future policy benefits payable include $2.3 billion at December 31, 2017 and $2.2 billion at December 31, 2016 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was a $168 million additional liability at December 31, 2017 and $77 million additional liability at December 31, 2016. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual premium rate increase, interest, morbidity, mortality, persistency, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, material future adjustments to reserves could be required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets. During 2017, we performed loss recognition testing comparing our existing future policy benefits payable with the present value of future gross premiums associated with our closed block of long-term care insurance policies and determined that no premium deficiency existed at December 31, 2017.

Deferred acquisition costs included $3 million and $16 million associated with our individual commercial medical policies at December 31, 2017 and December 31, 2016, respectively. Future policy benefits payable associated with our individual commercial medical policies were $19 million at December 31, 2017 and $86 million at December 31, 2016. The decline in deferred acquisition costs and future policy benefits payable primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies. For a detailed discussion refer to Note 2.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, and annuities in run-off status, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods

used to determine future policy benefits payable as detailed in Note 2. Excluding reinsurance associated with the Health Care Reform Law discussed in Note 2, reinsurance recoverables, included in other current and long-term assets, were $824 million at December 31, 2017 and $822 million at December 31, 2016. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 33% at December 31, 2017 and approximately 34% at December 31, 2016. Premiums ceded were $969 million in 2017, $842 million in 2016 and $821 million in 2015. Benefits ceded were $844 million in 2017, $767 million in 2016, and $666 million in 2015. Ceded premium and benefits reflect a July 1, 2014 amendment ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2017 presented below:

Reinsurer	Total Recoverable	A.M. Best Rating at December 31, 2017
	(in millions)	
Munich American Reassurance Company	$ 259	A+ (superior)
Protective Life Insurance Company	181	A+ (superior)
Westport Insurance Corporation, a Swiss Re Corporation subsidiary	134	A+ (superior)
General Re Life Corporation, a Berkshire Hathaway subsidiary	133	A++ (superior)
All others	117	A+ to A- (superior to excellent)
	$ 824	

The all other category represents 18 reinsurers with individual balances less than $71 million. Three of these reinsurers with recoverables of $87 million are subject to trust or funds withheld accounts, requiring amounts at least equal to the total recoverable from each of these reinsurers.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.:

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries as of December 31, 2017 and 2016, and the related consolidated statements of income, comprehensive income, stockholders’ equity and cash flows for each of the three years in the period ended December 31, 2017, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the “consolidated financial statements”). We also have audited the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2017 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company’s consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company’s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company’s internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations

of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

PricewaterhouseCoopers LLP (signed)
Louisville, Kentucky
February 16, 2018

We have served as the Company's auditor since 1968.

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2017 and 2016 follows:

	2017			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 13,762	$ 13,534	$ 13,282	$ 13,189
Income before income taxes	1,689	1,042	799	490
Net income	1,115	650	499	184
Basic earnings per common share (1)	$ 7.54	$ 4.49	$ 3.46	$ 1.30
Diluted earnings per common share (1)	$ 7.49	$ 4.46	$ 3.44	$ 1.29

	2016			
	First	Second	Third	Fourth (2)(3)
	(in millions, except per share results)			
Total revenues	$ 13,800	$ 14,007	$ 13,694	$ 12,878
Income (loss) before income taxes	500	636	902	(486)
Net income (loss)	254	311	450	(401)
Basic earnings (loss) per common share	$ 1.70	$ 2.08	$ 3.01	$ (2.68)
Diluted earnings (loss) per common share (1)	$ 1.68	$ 2.06	$ 2.98	$ (2.68)

(1) The calculation of earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year. For 2017, the sum of quarterly amounts do not equal full year results due to share repurchases throughout the year including two different accelerated share repurchase programs. In addition, for 2016, the sum of quarterly amounts do not equal full year results due to the anti-dilutive impact of a loss in the fourth quarter. The loss position in the fourth quarter required the use of basic weighted-average common shares outstanding in the calculation of diluted loss per share.

(2) The fourth quarter of 2016 includes an expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our closed block of long-term care insurance policies.

(3) Total revenue for 2016 includes a reduction of $583 million ($367 million after-tax, or $2.43 per diluted common share) in premiums associated with the write-off of risk corridor receivables.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2017, we as the principal executive officer and the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2017. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2017, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2017 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 138.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2017 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Bruce D. Broussard
President and Chief Executive Officer (Principal Executive Officer)

Brian A. Kane
Chief Financial Officer (Principal Financial Officer)

Cynthia H. Zipperle
Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2018, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	55	President and Chief Executive Officer, Director	12/11	(1)
Roy A. Beveridge, M.D.	60	Chief Medical Officer	06/13	(2)
Beth Bierbower	59	Segment President, Group Business	03/17	(3)
Jody L. Bilney	56	Chief Consumer Officer	04/13	(4)
Sam Deshpande	54	Chief Risk Officer	07/17	(5)
William Fleming, PharmD	50	Segment President, Healthcare Services	03/17	(6)
Christopher H. Hunter	49	Chief Strategy Officer	01/14	(7)
Timothy S. Huval	51	Chief Human Resources Officer	12/12	(8)
Brian A. Kane	45	Chief Financial Officer	06/14	(9)
Brian P. LeClaire	57	Chief Information Officer	08/11	(10)
Heidi S. Margulis	64	Chief Corporate Affairs Officer	12/95	(11)
Christopher M. Todoroff	55	Chief Legal Counsel	08/08	(12)
Alan Wheatley	50	Segment President, Retail	03/17	(13)
Cynthia H. Zipperle	55	Senior Vice President and Chief Accounting Officer	12/14	(14)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Beveridge currently serves as Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(3) Ms. Bierbower currently serves as Segment President, Group Business, having held this position since March 2017. Prior to that, she served as the Segment President, Employer Group, and also previously led the Company's Specialty Benefits area, including dental, vision, life, disability and workplace voluntary benefits. Ms. Bierbower joined the Company in 2001.

(4) Ms. Bilney currently serves as Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(5) Mr. Deshpande currently serves as Chief Risk Officer, having held this position since joining the Company in July 2017. Before joining Humana, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(6) Mr. Fleming currently serves as Segment President, Healthcare Services, where he is responsible for Humana's clinical and pharmacy businesses that service all Humana segments, having held this position since March of 2017. Prior to that, he served as President of the Company's pharmacy business. Mr. Fleming joined the Company in 1994.

(7) Mr. Hunter currently serves as Chief Strategy Officer, having held this position since joining the Company in January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(8) Mr. Huval currently serves as Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(9) Mr. Kane currently serves as Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(10) Mr. LeClaire currently serves as Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(11) Ms. Margulis currently serves as Chief Corporate Affairs Officer, leading strategy development and execution for Humana's state and federal government relations, advocacy and public policy initiatives, including strategic alliance relationships in national and key local markets. Ms. Margulis joined the Company in November 1985, and has held her current position since December 2014.

(12) Mr. Todoroff currently serves as Chief Legal Officer, having held this position since August 2008. Prior to joining the Company, Mr. Todoroff served as Vice President, Senior Corporate Counsel and Corporate Secretary for Aetna Inc. from 2006 through July 2008. Mr. Todoroff joined Aetna's Legal Department in 1995 and held various positions of increasing responsibility.

(13) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his 25-year career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(14) Mrs. Zipperle currently serves as Senior Vice President, Chief Accounting Officer, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com. Any waiver of the application of the Humana Inc. Principles of Business Ethics to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;

- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the captions "Corporate Governance – Organization & Compensation Committee – Compensation Committee Interlocks and Insider Participation," "Director Compensation," "Compensation Discussion and Analysis," "Organization & Compensation Committee Report," and "Executive Compensation" of such Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2017 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	863,128	$ 181.436	5,467,598	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	863,128	$ 181.436	5,467,598	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) Of the number listed above, 2,387,597 can be issued as restricted stock at December 31, 2017 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions "Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Security Ownership of Directors and Executive Officers" in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 19, 2018 appearing under the caption "Audit Committee Report" of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2017 and 2016 and for the years ended December 31, 2017, 2016 and 2015
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2017, 2016 and 2015

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

2.1 Agreement and Plan of Merger, dated as of July 2, 2015 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 2.1 to Humana Inc.'s Current Report on Form 8-K filed on July 7, 2015).

2.2 Letter Agreement, dated as of December 21, 2016, between Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on December 22, 2016).

2.3 Termination letter dated as of February 14, 2017, by and among Humana Inc., Aetna Inc., Echo Merger Sub, Inc. and Echo Merger Sub LLC (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on February 15, 2017).

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dates as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006, File No.001-05975).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e)	Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).
(f)	Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).
(g)	There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.
(h)	Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).
(i)	Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).
(j)	Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(k)	Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(l)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(m)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017.
(n)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017.
(o)	Twelfth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017.
(p)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017.
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(c)*	Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 21, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).

(d)*	Form of Change of Control Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).
(e)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).
(f)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).
(g)*	Humana Inc. Executive Severance Policy (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s current report on Form 8-K filed on November 22, 2017).
(h)*	Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).
(i)*	Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).
(j)*	Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).
(k)*	Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).
(l)*	Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).
(m)* **	Form of Company's Restricted Stock Unit Agreement with Time/Performance Vesting and Agreement not to Compete or Solicit, under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(t) to Humana Inc.'s Annual Report on Form 10-K/A filed on January 30, 2014).
(n)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(o)*	Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.
(p)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(q)	Five-Year $2 Billion Amended and Restated Credit Agreement , dated as of May 22, 2017, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., PNC Bank, National Association, U.S. Bank National Association, and Wells Fargo Bank, National Association, as Documentation Agents, and J.P. Morgan Chase Bank, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citigroup Global Markets, Inc., PNC Capital Markets LLC, U.S. Bank National Association, and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on May 22, 2017).
(r)	Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(s)	Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(t)	Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(u)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(v)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(w)	Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(x)	Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).
(y)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(z)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(oo) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(aa)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(pp) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(bb)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(cc)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(dd)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).
(ee)*	Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as March 3, 2011 (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(ff)**	Form of Amendment to Change of Control Agreement between Humana Inc. and various executive officers (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).
(gg)*	Humana Inc. Change in Control Policy (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on November 22, 2017).
(hh)*	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).
(ii)	Master Confirmation by and between Humana Inc. and Goldman, Sachs & Co., dated February 22, 2017 (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on February 27, 2017).

(jj)	Master Confirmation by and between Humana Inc. and Bank of America, N.A., dated December 21, 2017 (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on December 22, 2017).
(kk)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(ll)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(mm)*	Voluntary Release and Separation Agreement, dated as of April 1, 2017, by and between Humana Inc. and James E. Murray (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on April 3, 2017).
(nn)†	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K filed on February 16, 2018).
12 †	Computation of ratio of earnings to fixed charges.
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.
101	The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2017 and 2016; (ii) the Consolidated Statements of Income for the years ended December 31, 2017, 2016 and 2015; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2017, 2016 and 2015; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2017, 2016, and 2015; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2017, 2016 and 2015; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(p), and Exhibits 10(y) through and including 10(dd), as well as 10(ff),10(gg), 10(kk), 10(ll) and 10(mm) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2017	2016
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 383	$ 1,710
Investment securities	305	300
Receivable from operating subsidiaries	1,042	1,136
Other current assets	245	122
Total current assets	1,975	3,268
Property and equipment, net	1,091	1,086
Investments in subsidiaries	16,810	15,276
Other long-term assets	426	374
Total assets	$ 20,302	$ 20,004
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 4,311	$ 4,107
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	41	38
Short-term borrowings	150	300
Other current liabilities	896	708
Total current liabilities	5,426	5,181
Long-term debt	4,770	3,792
Notes payable to operating subsidiaries	9	9
Other long-term liabilities	255	337
Total liabilities	10,460	9,319
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,572,458 shares issued at December 31, 2017 and 198,495,007 shares issued at December 31, 2016	33	33
Capital in excess of par value	2,445	2,562
Retained earnings	13,670	11,454
Accumulated other comprehensive income (loss)	19	(66)
Treasury stock, at cost, 60,893,762 shares at December 31, 2017 and 49,189,811 shares at December 31, 2016	(6,325)	(3,298)
Total stockholders' equity	9,842	10,685
Total liabilities and stockholders' equity	$ 20,302	$ 20,004

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 1,864	$ 1,683	$ 1,469
Investment and other income, net	57	42	5
	1,921	1,725	1,474
Expenses:			
Operating costs	1,801	1,519	1,347
Merger termination fee and related costs, net	(936)	104	23
Depreciation	332	302	252
Interest	243	189	186
	1,440	2,114	1,808
Income (loss) before gain on sale of business, income taxes and equity in net earnings of subsidiaries	481	(389)	(334)
Gain on sale of business	—	—	270
Income (loss) before income taxes and equity in net earnings of subsidiaries	481	(389)	(64)
Provision (benefit) for income taxes	61	(107)	(70)
Income (loss) before equity in net earnings of subsidiaries	420	(282)	6
Equity in net earnings of subsidiaries	2,028	896	1,270
Net income	$ 2,448	$ 614	$ 1,276

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Net income	$ 2,448	$ 614	$ 1,276
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	149	(101)	(114)
Effect of income taxes	(55)	38	42
Total change in unrealized investment gains/losses, net of tax	94	(63)	(72)
Reclassification adjustment for net realized gains included in investment income	(14)	(96)	(146)
Effect of income taxes	5	35	53
Total reclassification adjustment, net of tax	(9)	(61)	(93)
Other comprehensive income (loss), net of tax	85	(124)	(165)
Comprehensive income	$ 2,533	$ 490	$ 1,111

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Net cash provided by operating activities	$ 2,423	$ 1,848	$ 953
Cash flows from investing activities:			
Proceeds from sale of business	—	—	1,055
Capital contributions to operating subsidiaries	(695)	(895)	(833)
Purchases of investment securities	(53)	(151)	(507)
Proceeds from sale of investment securities	—	25	18
Maturities of investment securities	51	143	108
Purchases of property and equipment, net	(359)	(382)	(378)
Net cash used in investing activities	(1,056)	(1,260)	(537)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	1,779	—	—
(Repayments) proceeds from issuance of commercial paper, net	(153)	(2)	298
Repayment of long-term debt	(800)	—	—
Change in book overdraft	3	5	(16)
Common stock repurchases	(3,365)	(104)	(385)
Dividends paid	(220)	(177)	(172)
Tax benefit from stock-based compensation	—	—	15
Proceeds from stock option exercises and other	62	11	22
Net cash used in financing activities	(2,694)	(267)	(238)
(Decrease) increase in cash and cash equivalents	(1,327)	321	178
Cash and cash equivalents at beginning of year	1,710	1,389	1,211
Cash and cash equivalents at end of year	$ 383	$ 1,710	$ 1,389

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

Related Party

Refer to Note 2 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of our related party transactions. A related party note receivable is included with other long-term assets in our condensed balance sheet at December 31, 2017 and December 31, 2016 in the amount of $349 million and $314 million, respectively. We have also entered into a revolving note agreement providing a line of credit up to $55 million under which $18 million was outstanding at December 31, 2017, and we had no balance outstanding at December 31, 2016. The related interest income of $35 million and $30 million for 2017 and 2016, respectively, is included in investment and other income in our condensed statements of income.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $1.4 billion in 2017, $763 million in 2016, and $493 million in 2015.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by our parent company in the event of insolvency for: (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent has also guaranteed the obligations of our military services subsidiaries.

Notes Receivables from Operating Subsidiaries

We funded certain subsidiaries with surplus note agreements. These notes are generally non-interest bearing and may not be entered into or repaid without the prior approval of the applicable Departments of Insurance or other state regulatory authorities.

Notes Payable to Operating Subsidiaries

We borrowed funds from certain subsidiaries with notes generally collateralized by real estate. These notes, which have various payment and maturity terms, bear interest ranging from 2.14% to 6.65% and are payable in 2018 and 2019. We recorded interest expense of $1 million related to these notes for each of the years ended December 31, 2017, 2016 and 2015.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS—(Continued)

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $8.0 billion and $7.7 billion as of December 31, 2017 and 2016, respectively, which exceeded aggregate minimum regulatory requirements of $4.8 billion in both years. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2018 is approximately $1.1 billion in the aggregate. This compares to dividends that were paid to our parent company in 2017 of approximately $1.4 billion. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Our parent company funded a subsidiary capital contribution of approximately $535 million in the first quarter of 2017 for reserve strengthening associated with our closed block of long-term care insurance policies discussed further in Note 18 of the notes to consolidated financial statements in this Annual Report on Form 10-K.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc. During 2017, 2016 and 2015, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2017, 2016, and 2015
(in millions)

	Balance at Beginning of Period	Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2017	$ 118	$ —	$ 20	$ (10)	$ (32)	$ 96
2016	101	—	39	19	(41)	118
2015	137	(39)	61	(7)	(51)	101
Deferred tax asset valuation allowance:						
2017	(49)	—	—	—	—	(49)
2016	(42)	—	(7)	—	—	(49)
2015	(48)	—	6	—	—	(42)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

Date: February 16, 2018

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Chief Financial Officer (Principal Financial Officer)	February 16, 2018
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 16, 2018
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 16, 2018
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 16, 2018
/s/ FRANK BISIGNANO **Frank Bisignano**	Director	February 16, 2018
/s/ KAREN DESALVO MD, MPH, MSc **Karen DeSalvo, MD, MPH, MSc**	Director	February 16, 2018
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 16, 2018
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 16, 2018
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 16, 2018
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 16, 2018
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 16, 2018
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 16, 2018
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 16, 2018
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 16, 2018

Exhibit 10(nn)

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT WITH PERFORMANCE VESTING
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>**,** an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors (the **"Board"**) and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Performance-Based Restricted Stock Units (the "Restricted Stock Units") (which represents the target amount of shares available as set out on Appendix A. Each Restricted Stock Unit represents the right of the Grantee to receive (i) one (1) Share on the date of distribution provided for in Section 1.E. In addition, the Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("DERs"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to the Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. **Restrictions and Non-Transferability.** The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. **Vesting of Shares.** Subject to the terms set forth below, if as of the third anniversary of the Date of Grant (the "Vest Date"), the Grantee and the Company have achieved the performance goals to be set forth in Appendix A, the Restricted Stock Units and related DERs shall vest to the extent such performance goals have been achieved.

Effective on the Vest Date, any portion of the Restricted Stock Units and the related DERs for which the performance goals set forth in Appendix A have not been satisfied shall be immediately forfeited. However, (i) all of the unvested Restricted Stock Units and DERs will immediately vest at target level on (A) the date of termination due to the death of the Grantee or (B) the date of termination of the Grantee's employment by the Company or its applicable affiliate for any reason other than Cause, or by the Grantee with Good Reason (as defined below), in each case within two (2) years following a Change in Control (a "**Change in Control Termination**"), if such termination of employment occurs prior to a Vesting Date or (ii) upon the termination of the Grantee's employment due to Retirement, a prorated portion of the Restricted Stock Units (and related DERs) that would have vested on the next scheduled Vesting Date shall vest on the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months the Grantee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current restricted Vesting Period, multiplied by (B) the total number of Restricted Stock Units that were scheduled to vest on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant. For the purposes of this Agreement, "**Good Reason**" means, (a) if the Grantee is a party to an employment or a severance agreement with the Company or one of its Subsidiaries in which "Good Reason" is defined, the occurrence of any circumstances defined as "Good Reason" in such employment or severance agreement, or (b) if the Grantee is not a party to an employment or severance agreement with the Company or one of the Subsidiaries in which "Good Reason" is defined, the relocation of the Grantee's office at which the Grantee is to perform his or her duties to a location more than thirty (30) miles from the location at which the Grantee performed his or her duties prior to the Change in Control.

D. Forfeiture. Upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units have vested pursuant to Section I.C., other than a termination in the event of Grantee's Retirement, death, Disability or a Change in Control Termination, the Restricted Stock Units and DERs shall thereupon be forfeited immediately by Grantee. In the event of Grantee's Retirement, a prorated portion of the Restricted Stock Units and DERs that would have vested on the next Vesting Date shall vest in accordance with Section I.C.(ii) and the Grantee shall forfeit the remaining unvested portion of the Restricted Stock Units and DERs; provided, however, that the Committee may determine, in its sole discretion, that some or all of the unvested Restricted Stock Units and DERs held by the Grantee that would otherwise be forfeited as of the date of Retirement shall vest. For the avoidance of doubt, no Restricted Stock Units or DERs shall be forfeited upon Grantee's termination of employment due to Disability, with such Restricted Stock Units and DERs continuing to vest in accordance with the Vesting Dates provided in Section I.C.

E. Distributions. The Company shall issue to Grantee (or, if applicable, the Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to the Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted

Stock Units vest in connection with the Grantee's Change in Control Termination, then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than the Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. **Taxes**. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT. Grantee acknowledges that Grantee's continued employment with the Company and the grant of the Restricted Stock Units evidenced hereby is sufficient consideration for this Agreement, including, without limitation, the restrictions imposed by this Section II.

A. **Agreement Not To Compete.** Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee shall not, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, engage in business with, be employed by, or render any consultation or business advice or other services with respect to, any business which provides or offers products or services which compete with any Company Business, in any geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

B. **Agreement Not To Solicit.** Grantee hereby covenants and agrees that for a period commencing on the date hereof and ending twelve (12) months after the effective date of Grantee's termination of employment with the Company, Grantee, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, material shareholder, investor or principal of, or consultant or independent contractor with, another entity, shall not:

1. Interfere with the relationship of the Company and/or any of its affiliates and any of its employees, agents, representatives, consultants or advisors.

2. Divert, or attempt to cause the diversion from the Company and/or any of its affiliates, any Company Business, nor interfere with relationships of the Company and/or any of its affiliates with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers.

3. Solicit, recruit or otherwise induce or influence any employee of the Company and/or any of its affiliates to accept employment in any business which competes with the Company Business, in any of the geographic areas in which the Company and/or any of its affiliates is then currently doing Company Business.

C. Definitions.

For purposes of Sections II.A and B, the following definitions apply.

1. "Company Business" shall mean any business related to a service or product offered by the Company and/or any of its affiliates during the two-year period immediately preceding the Grantee's termination date that Grantee engaged in or rendered any consultation or business advice or other services with respect to, during Grantee's employment with the Company and/or any of its affiliates.

2 "Geographic area" shall mean any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II.A and II.B shall remain in full force and effect.

2. In the event Grantee is discharged by Company other than with Cause prior to the vesting herein of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect only if the Company, solely at its option, pays to Grantee an amount at least equal to Grantee's then current annual base salary, whether such amount is paid pursuant to this provision or pursuant to any other severance or separation plan or other plan or agreement between Grantee and Company.

3. In the event Grantee is discharged by Company other than with Cause prior to vesting herein of the Restricted Stock Unit, the prohibitions set forth in Section II.B above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect Of a Change In Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D., in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Grantee's employment termination date with the Company or its successor, to the Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary, plus Grantee's target potential bonus pursuant to any bonus plan in which Grantee participated as of the date of the Change in Control. Such sums shall be in addition to any other amounts paid or payable to Grantee with respect to other change in control agreements. For the avoidance of doubt, the provisions of this Section IIE shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Grantee and

the Company, or (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II.B. shall remain in full force and effect.

F. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement, shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. **Injunctive Relief; Invalidity of Any Provision**. Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II hereof are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. **Amendment**. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. **Governing Law.** Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard

to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. **No Employment Agreement**. Nothing herein confers on the Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. **Severability.** If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. **Defined Terms.** Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

G. **Execution.** If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker-dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. **Section 409A.** All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of the Grantee's termination of employment, shall not be delivered until the date that the Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if the Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of the Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to the Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:

Joseph C. Ventura

Senior Vice President, Associate General Counsel & Corporate Secretary

BY:

BRUCE D. BROUSSARD

President & Chief Executive Officer

"Grantee"

<first_name> <middle_name> <last_name>

Exhibit 12

Humana Inc.
Computation of Ratio of Earnings to Fixed Charges

	For the twelve months ended December 31,				
	2017	**2016**	**2015**	**2014**	**2013**
	(Dollars in millions)				
Income before income taxes	$ 4,020	$ 1,552	$ 2,431	$ 2,170	$ 1,921
Fixed charges	310	249	253	267	216
Total earnings	$ 4,330	$ 1,801	$ 2,684	$ 2,437	$ 2,137
Interest charged to expense	$ 242	$ 189	$ 186	$ 192	$ 140
One-third of rent expense	68	60	67	75	76
Total fixed charges	$ 310	$ 249	$ 253	$ 267	$ 216
Ratio of earnings to fixed charges (1)(2)	14.0x	7.2x	10.6x	9.1x	9.9x

Notes
(1) For the purposes of determining the ratio of earnings to fixed charges, earnings consist of income before income taxes and fixed charges. Fixed charges include gross interest expense, amortization of deferred financing expenses and an amount equivalent to interest included in rental charges. One-third of rental expense represents a reasonable approximation of the interest amount.
(2) There are no shares of preferred stock outstanding.

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARIZONA
1. SeniorBridge Family Companies (AZ), Inc.

ARKANSAS
1. Humana Regional Health Plan, Inc.

CALIFORNIA
1. Humana EAP and Work-Life Services of California, Inc.
2. Humana Health Plan of California, Inc.
3. SeniorBridge Family Companies (CA), Inc.

CONNECTICUT
1. SeniorBridge Family Companies (CT), Inc.

DELAWARE
1. American Tax Credit Corporate Georgia Fund III, L.L.C.
2. Availity, L.L.C.
3. CompBenefits Corporation
4. CompBenefits Direct, Inc.
5. DefenseWeb Technologies, Inc.
6. Emphesys, Inc.
7. Go365, LLC
8. Health Value Management, Inc.
9. HUM Provider Holdings, LLC
10. Humana at Home, Inc.
11. Humana Government Business, Inc.
12. Humana Inc.
13. Humana Innovation Enterprises, Inc.
14. Humana Pharmacy, Inc.
15. Humana Veterans Healthcare Services, Inc.
16. Humana WellWorks LLC
17. HumanaDental, Inc.
18. Primary Care Holdings, Inc.
19. Transcend Insights, Inc.
20. Transcend Population Health Management, LLC

FLORIDA
1. 154th Street Medical Plaza, Inc.
2. 1st Choice Home Health Care, LLC
3. 54th Street Medical Plaza, Inc.
4. American Eldercare of North Florida, LLC
5. American Eldercare, Inc.
6. CAC Medical Center Holdings, Inc.
7. CAC-Florida Medical Centers, LLC
8. Care Partners Home Care, LLC
9. CarePlus Health Plans, Inc.
10. CompBenefits Company
11. Complex Clinical Management, Inc.
12. Continucare Corporation
13. Continucare MDHC, LLC
14. Continucare Medical Management, Inc.
15. Continucare MSO, Inc.
16. HUM-e-FL, Inc.

17. Humana At Home 1, Inc.
18. Humana Dental Company
19. Humana Health Insurance Company of Florida, Inc.
20. Humana Medical Plan, Inc.
21. METCARE of Florida, Inc.
22. Metropolitan Health Networks, Inc.
23. Naples Health Care Specialists, LLC
24. Nursing Solutions, LLC
25. Partners in Integrated Care, Inc.
26. SeniorBridge Family Companies (FL), Inc.
27. SeniorBridge-Florida, LLC

GEORGIA
1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS
1. CompBenefits Dental, Inc.
2. Comprehensive Health Insights, Inc.
3. Dental Care Plus Management, Corp.
4. Humana Benefit Plan of Illinois, Inc.
5. Humana Dental Concern, Ltd.
6. SeniorBridge Family Companies (IL), Inc.

INDIANA
1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY
1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. CHA Service Company
4. Humana Active Outlook, Inc.
5. Humana Health Plan, Inc.
6. Humana Insurance Company of Kentucky
7. Humana MarketPOINT, Inc.
8. Humana Pharmacy Solutions, Inc.
9. Humco, Inc.
10. Preservation on Main, Inc.
11. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MARYLAND
1. SeniorBridge Family Companies (MD), Inc.

MASSACHUSETTS
1. Humana at Home (MA), Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

MISSOURI
1. SeniorBridge Family Companies (MO), Inc.

NEW JERSEY
1. SeniorBridge Family Companies (NJ), Inc.

NEW YORK
1. Harris, Rothenberg International Inc.
2. Humana Health Company of New York, Inc.
3. Humana Insurance Company of New York
4. SeniorBridge Care Management, Inc.
5. SeniorBridge Family Companies (NY), Inc.

NORTH CAROLINA
1. SeniorBridge (NC), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.
2. Hummingbird Coaching Systems LLC
3. SeniorBridge Family Companies (OH), Inc.

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.
2. SeniorBridge Family Companies (PA), Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

SOUTH CAROLINA
1. Kanawha Insurance Company

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. DentiCare, Inc.
3. Emphesys Insurance Company
4. Humana At Home (Dallas), Inc.
5. Humana At Home (Houston), Inc.
6. Humana At Home (San Antonio), Inc.
7. Humana At Home (TLC), Inc.
8. Humana Behavioral Health, Inc.
9. Humana Health Plan of Texas, Inc.
10. ROHC, L.L.C.
11. Texas Dental Plans, Inc.

UTAH
1. Humana Medical Plan of Utah, Inc.

VERMONT
1. Managed Care Indemnity, Inc.

VIRGINIA
1. KMG America Corporation
2. SeniorBridge Family Companies (VA), Inc.

WASHINGTON
1. Arcadian Health Plan, Inc.

WISCONSIN

1. CareNetwork, Inc.
2. Humana Insurance Company
3. Humana Wisconsin Health Organization Insurance Corporation
4. HumanaDental Insurance Company
5. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and Form S-3 (No. 333-202623) of Humana Inc. of our report dated February 16, 2018 relating to the financial statements, financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 16, 2018

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 16, 2018

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 16, 2018

Signature: /s/ BRIAN A. KANE

Brian A. Kane
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2017 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 16, 2018

/s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

February 16, 2018

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2018
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (502) 580-1000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of exchange on which registered**
Common stock, $0.16 2/3 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company,"and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2018 was $41,129,697,151 calculated using the average price on June 30, 2018 of $299.02.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2019 was 135,566,909.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 18, 2019.

HUMANA INC.
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For the Year Ended December 31, 2018

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Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

As of December 31, 2018, we had approximately 17 million members in our medical benefit plans, as well as approximately 6 million members in our specialty products. During 2018, 81% of our total premiums and services revenue were derived from contracts with the federal government, including 15% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 636,800 members as of December 31, 2018.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2018 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2018 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Business Segments

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, include comprehensive managed care benefits generally through a participating network of physicians, hospitals, and other providers. Preferred provider organizations, or PPOs, provide members the freedom to choose any health care provider. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2018:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 35,656	63.2%
Group Medicare Advantage	6,103	10.8%
Medicare stand-alone PDP	3,584	6.4%
Total Retail Medicare	45,343	80.4%
State-based Medicaid	2,255	4.0%
Medicare Supplement	510	0.9%
Total premiums	48,108	85.3%
Services	11	—%
Total premiums and services revenue	$ 48,119	85.3%

Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage, or MA, plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. For more information refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data and Item 1A. - Risk Factors.

At December 31, 2018, we provided health insurance coverage under CMS contracts to approximately 3,064,000 individual Medicare Advantage members, including approximately 636,800 members in Florida. These Florida contracts accounted for premiums revenue of approximately $8.2 billion, which represented approximately 23.0% of our individual Medicare Advantage premiums revenue, or 14.6% of our consolidated premiums and services revenue for the year ended December 31, 2018.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2019, and all of our product offerings filed with CMS for 2019 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled "Medicare Part D." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2019, and all of our product offerings filed with CMS for 2019 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

State-based Medicaid Contracts

Our state-based contracts allow us to serve members enrolled in state-based Medicaid programs including Temporary Assistance to Needy Families, or TANF, Aged, Blind, and Disabled, or ABD, Long-Term Support Services, or LTSS, and the CMS Financial Alignment dual eligible demonstration programs. TANF and ABD programs are traditional Medicaid programs that are state and federally funded and provide cash assistance and supportive services to assist qualifying aged, blind, or disabled individuals, as well as families with children under age 18, helping them achieve economic self-sufficiency. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term support services for our members who receive home and community or institution-based services for long-term care. Our contracts are generally for three to five year terms.

We have contracts to serve Medicaid eligible members in Florida and Kentucky under traditional programs, as well as contracts in Florida under the LTSS program. Our Kentucky Medicaid contract is subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. States require special coordinating contracts for plans to offer Medicare Advantage dual eligible special needs plans, or D-SNPs. These largely operate separate from traditional Medicaid and LTSS programs. Some states are moving to support the dual eligible population by linking D-SNP participation to enrollment in a plan that also participates in a state-based Medicaid program to coordinate and integrate both Medicare and Medicaid benefits. Beginning in 2021, based on new federal requirements, D-SNPs will be required to more fully integrate Medicare and Medicaid benefits and states will have authority to require linkages to state-based traditional Medicaid and/or LTSS contracts or alternatively, allow D-SNPs to operate without a link to such state-based contracts while meeting additional coordination standards; CMS has yet to finalize regulations.

We currently serve dual eligible members under the CMS stand-alone dual eligible demonstration program in Illinois, and continue to serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision and life insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2018:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,444	9.7%
Specialty	1,359	2.4%
Total premiums	6,803	12.1%
Services	835	1.5%
Total premiums and services revenue	$ 7,638	13.6%
Intersegment services revenue	$ 18	n/a

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses.

Our administrative services only, or ASO, products are offered to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing substantially all of the cost of health benefits. However, substantially all of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

Employers can customize their offerings with optional benefits such as dental, vision, and life products. We also offer optional benefits such as dental and vision to individuals.

Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. On January 1, 2018, we began to deliver services under the T2017 East Region contract. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2018:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 20,514	n/a
Provider services	1,994	n/a
Clinical care services	662	n/a
Total intersegment revenue	$ 23,170	
External services revenue:		
Pharmacy solutions	$ 203	0.4%
Provider services	228	0.4%
Clinical care services	176	0.3%
Total external services revenue	$ 607	1.1%

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through Humana Pharmacy, Inc.

Provider services

We operate full-service, multi-specialty medical centers in a number of states, primarily in Florida and Texas, staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry. Our care delivery subsidiaries operate our medical center business through both employed physicians and care providers, and through third party management service organizations with whom we contract to arrange for and manage certain clinical services.

We also operate Transcend, a Medical Services Organization, or MSO, that coordinates medical care for Medicare Advantage beneficiaries primarily in four states. Transcend provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Transcend collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions. Transcend represents a key component of our integrated care delivery model which we believe is scalable to new markets.

During 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. In addition, during 2018, we acquired Family Physicians Group, or FPG, which serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home ®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2018, we have enrolled approximately 716,000 members, with complex chronic conditions participating in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. These members may not be unique to each program since members have the ability to enroll in multiple programs. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities with our acquisition of a 40% minority interest in Kindred at Home, Inc., or Kindred at Home, and Curo Health Services, or Curo, which combined creates the nation's largest home health and hospice provider with 65% overlap with our individual Medicare Advantage business. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management and wellness programs. These programs use our capabilities that enable us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

Our care management programs take full advantage of the population health, wellness and clinical applications offered by CareHub, our clinical management tool used by providers and care managers across the company to help our members achieve their best health, to offer various levels of support, matching the intensity of the support to the needs of members with ongoing health challenges through telephonic and onsite programs. These programs include Personal Nurse, chronic condition management, and case management as well as programs supporting maternity, cancer, neonatal intensive care unit, and transplant services.

Wellness

We offer wellness solutions including our Go365 wellness and loyalty rewards program, employee assistance program, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Go365 program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual's needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

Our Individual Commercial Segment Products

Our individual health plans were marketed under the HumanaOne brand. We offered products both on and off of the public exchange.

We discontinued substantially all off-exchange individual commercial medical plans effective January 1, 2017, and we exited our remaining individual commercial medical business effective January 1, 2018.

Other Businesses

Other Businesses includes those businesses that do not align with the reportable segments previously described, primarily our closed-block long-term care insurance policies, which was sold in 2018. For a detailed discussion of the sale refer to Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31, 2018, by market and product:

	Retail Segment				Group and Specialty Segment					
	(in thousands)									
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Total	Percent of Total
Florida	636.8	9.9	234.2	11.4	333.4	125.7	36.2	—	1,387.6	8.4%
Texas	246.9	241.9	305.1	10.6	—	171.6	30.4	—	1,006.5	6.1%
Kentucky	89.0	63.7	215.6	5.8	—	112.6	138.5	—	625.2	3.8%
California	70.9	0.2	484.4	20.3	—	—	—	—	575.8	3.5%
Georgia	114.2	2.2	124.5	11.1	—	158.5	45.2	—	455.7	2.7%
Illinois	108.7	23.3	185.2	5.7	7.7	46.0	76.8	—	453.4	2.7%
Ohio	128.6	22.1	184.3	45.8	—	44.6	27.5	—	452.9	2.7%
Missouri/Kansas	82.5	4.9	227.2	9.1	—	45.0	17.4	—	386.1	2.3%
North Carolina	149.5	0.5	172.6	6.0	—	—	—	—	328.6	2.0%
Tennessee	144.3	4.3	117.2	4.9	—	41.4	12.9	—	325.0	2.0%
Louisiana	161.1	12.1	61.3	2.2	—	59.6	13.5	—	309.8	1.9%
Wisconsin	58.7	10.0	121.6	6.3	—	68.7	36.8	—	302.1	1.8%
Indiana	103.5	6.8	145.8	9.0	—	21.2	12.6	—	298.9	1.8%
Virginia	121.6	3.1	159.1	8.6	—	—	—	—	292.4	1.8%
Michigan	52.9	12.9	140.2	3.4	—	2.8	0.4	—	212.6	1.3%
Arizona	76.0	0.4	97.6	4.8	—	25.0	5.5	—	209.3	1.3%
Pennsylvania	46.6	0.4	156.2	4.7	—	—	—	—	207.9	1.2%
South Carolina	87.0	0.5	71.3	5.2	—	—	—	—	164.0	1.0%
Military services	—	—	—	—	—	—	—	5,928.6	5,928.6	35.8%
Others	585.2	78.6	1,800.9	79.4	—	82.0	28.2	—	2,654.3	15.9%
Totals	3,064.0	497.8	5,004.3	254.3	341.1	1,004.7	481.9	5,928.6	16,576.7	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate for diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2018, approximately 1,128,500 members, or 6.8% of our medical membership, were covered under risk-based contracts, which provide all member benefits, including 942,000 individual Medicare Advantage members, or 30.7% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 181,200 HMO members, including 168,900 individual Medicare Advantage members, or 17.9% of the 942,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2018, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.5 billion, or 3.3% of total benefits expense, for the year ended December 31, 2018. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Set, or HEDIS, which is used by employers, government purchasers and the National

Committee for Quality Assurance (NCQA) to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or The Joint Commission.

Recredentialing of participating providers occurs every three years, unless otherwise required by state or federal regulations. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee composed of a peer group of providers reviews the applications of providers being considered for credentialing and recredentialing.

We maintain accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), and/or URAC. All Federal Employee Health Benefit Plans are required to be accredited. Certain commercial businesses, such as those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, population health management, credentialing, utilization management, network management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in many of our commercial, Medicare and Medicaid HMO/POS and PPO markets and our wellness program, Go365. Humana's pharmacy organization is accredited by URAC.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2018, we employed approximately 1,500 sales representatives, as well as approximately 1,400 telemarketing representatives who assisted in the marketing of Medicare, including Medicare Advantage and PDP, in our Retail segment and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. We use licensed independent brokers, independent agents, digital insurance agencies, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our specialty products.

Underwriting

Since 2014, the Patient Protection and Affordability Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, requires certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2018 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system, including the Health Care Reform Law.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2018 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, cybersecurity, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service. Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

Employees

As of December 31, 2018, we had approximately 41,600 employees and approximately 2,000 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. We continually review these estimates, however these estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Any reserve, including a premium deficiency reserve, may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from the Health Care Reform Law.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to

appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, any costs associated with exiting products, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee), and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

The policies and decisions of the federal and state governments regarding the Medicare, military and Medicaid programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives and our state-based contracts strategy, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products. In addition, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model and our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 80% of our total premiums and services revenue for the year ended December 31, 2018 generated from our Medicare products, including 15% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

The achievement of Star ratings of 4-Star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the

software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. We have been, and will likely continue to be, regular targets of attempted cybersecurity attacks and other security threats and may be subject to breaches of our information technology security systems. Although the impact of such attacks has not been material to our operations or results of operations, financial position, or cash flow through December 31, 2018, we can provide no assurance that we will be able to detect, prevent, or contain the effects of such cybersecurity attacks or other information security risks or threats in the future. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our businesses whose operations are subject to similar risks.

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our associates' or members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment and employment discrimination-related suits, employee benefit claims, stockholder suits and other securities laws claims, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;

- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts;
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;
- claims relating to dispensing of drugs associated with our in-house mail-order pharmacy; and
- professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought.

While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 85% of our total premiums and services revenue for the year ended December 31, 2018. These programs involve various risks, as described further below.

- At December 31, 2018, under our contracts with CMS we provided health insurance coverage to approximately 636,800 individual Medicare Advantage members in Florida. These contracts accounted for

approximately 15% of our total premiums and services revenue for the year ended December 31, 2018. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

- At December 31, 2018, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2018, primarily consisted of the TRICARE T2017 East Region contract replacing the 5-year T3 South Region contract that expired on December 31, 2017. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5 -year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

  CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic

differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of Medicare FFS (we refer to the process of accounting for errors in FFS claims as the "FFS Adjuster"). This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For Service business which we used to represent a proxy of the FFS Adjuster which has not yet been finalized. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We are studying the Proposed Rule and CMS' underlying analysis contained therein. We believe, however, that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and we expect to provide substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. We are also evaluating the potential impact of the Proposed Rule, and any related regulatory, industry or company reactions, all or any of which could have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk- adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the result of these reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

We believe that CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has filed a motion for reconsideration related to certain aspects of the Federal District Court's opinion and has simultaneously filed a notice to appeal the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $170 million and $279 million at December 31, 2018 and 2017, respectively.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the applicable year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations, including audits of risk adjustment data, are also conducted by state attorneys

general, CMS, HHS-OIG, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Health Care Reform Law could have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with a non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). Financing for these reforms come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the Health Care Reform Law or declare all or certain portions of the Health Care Reform Law unconstitutional, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes or judicial determinations may occur.

For additional information, please refer to the section entitled, "Health Care Reform" in "Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing in this annual report.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, including reductions in Medicare Advantage payment rates, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

In addition to the Health Care Reform Law, the health care industry in general and health insurance are subject to substantial federal and state government regulation:

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information, including requirements that insurers provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act and HIPAA mandate individual notification in the event of a breach of unsecured, individually identifiable health information, provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires HHS to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-

splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions, investments, joint ventures or strategic alliances may cause asset write-offs, restructuring costs or other expenses and may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives, and we may divest or wind down such businesses. There can be no assurance that we will be able to complete any such divestiture on terms favorable to us. The divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. In addition, divestitures may result in continued financial exposure to the divested businesses following the completion of the transaction. For example, in connection with a disposition, we may enter into transition or administrative service agreements, coinsurance arrangements, vendor relationships or other strategic relationships with the divested business, or we may agree to provide certain indemnities to the purchaser in any such transaction, each of which may result in additional expense and could have a material adverse effect on our result of operations.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected.

We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive

disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The U.S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy

business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would

increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2018:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	13	207	—	69	289
Texas	1	17	2	14	34
Kentucky	2	3	15	12	32
Arizona	—	17	—	6	23
Louisiana	—	6	—	10	16
Virginia	—	8	—	7	15
Illinois	—	5	—	10	15
California	—	2	—	12	14
Ohio	—	1	—	13	14
South Carolina	—	6	—	6	12
New York	—	—	—	13	13
Nevada	—	7	—	5	12
Puerto Rico	—	1	—	10	11
Indiana	—	5	—	5	10
Georgia	—	8	—	3	11
Washington	—	7	—	4	11
Tennessee	—	—	—	9	9
New Jersey	—	—	—	9	9
Colorado	—	5	—	3	8
Michigan	—	5	—	3	8
North Carolina	—	2	—	4	6
Others	—	9	1	38	48
Total	16	321	18	265	620

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of the medical centers included in the table above, approximately 44 of these facilities are leased or subleased to our contracted providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, qui tam litigation brought by individuals seeking to sue on behalf of the government, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM.

Holders of our Capital Stock

As of January 31, 2019, there were approximately 2,300 holders of record of our common stock and approximately 244,700 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2017 and 2018, under our Board approved quarterly cash dividend policy:

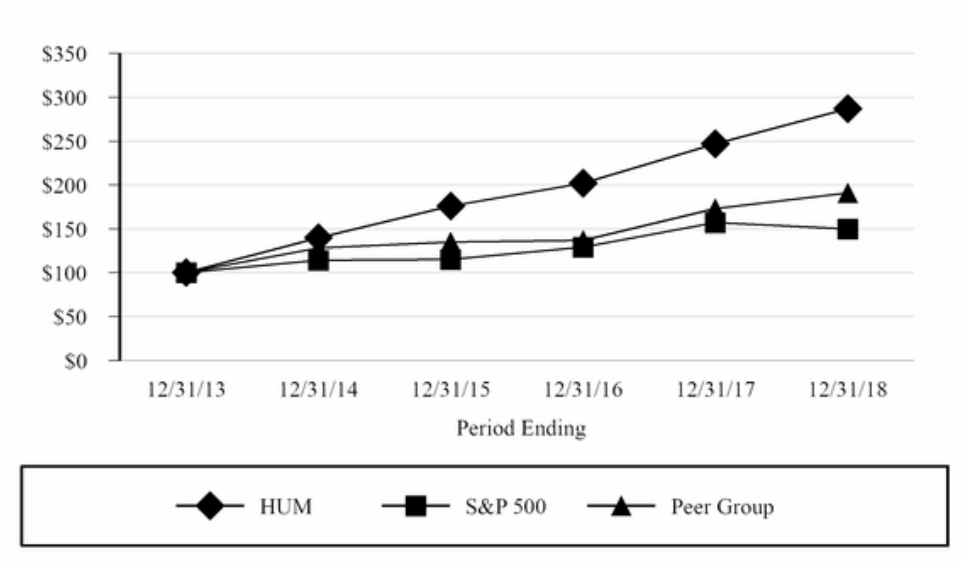
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2017 payments			
1/12/2017	1/27/2017	$0.29	$43
3/31/2017	4/28/2017	$0.40	$58
6/30/2017	7/31/2017	$0.40	$58
9/29/2017	10/27/2017	$0.40	$57
2018 payments			
12/29/2017	1/26/2018	$0.40	$55
3/30/2018	4/27/2018	$0.50	$69
6/29/2018	7/27/2018	$0.50	$69
9/28/2018	10/26/2018	$0.50	$69

On November 2, 2018, the Board declared a cash dividend of $0.50 per share that was paid on January 25, 2019 to stockholders of record on December 31, 2018, for an aggregate amount of $68 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2019, the Board declared a cash dividend of $0.55 per share payable on April 26, 2019 to stockholders of record on March 29, 2019.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2018. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2013, and that dividends were reinvested when paid.



	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
HUM	$ 100	$ 140	$ 176	$ 202	$ 247	$ 287
S&P 500	$ 100	$ 114	$ 115	$ 129	$ 157	$ 150
Peer Group	$ 100	$ 128	$ 135	$ 137	$ 173	$ 191

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2018 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2)
October 2018	—	$ —	—	$ 1,776,354,011
November 2018	1,937,797	309.63	1,937,797	1,176,354,010
December 2018	—	—	—	1,176,354,010
Total	1,937,797	$ 309.63	1,937,797	

(1) On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions, including pursuant to accelerated share repurchase agreements with investment banks, subject to certain regulatory restrictions on volume, pricing, and timing. On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman, Sachs & Co. LLC, or Goldman Sachs, to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of an $600 million increase in treasury stock, which reflects the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. Our remaining repurchase authorization was approximately $1,176 million as of February 21, 2019, excluding the $150 million pending final settlement of our November 2018 ASR.

(2) Excludes 0.15 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

	2018	2017	2016 (a)	2015	2014
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 54,941	$ 52,380	$ 53,021	$ 52,409	$ 45,959
Services	1,457	982	969	1,406	2,164
Investment income	514	405	389	474	377
Total revenues	56,912	53,767	54,379	54,289	48,500
Operating expenses:					
Benefits	45,882	43,496	45,007	44,269	38,166
Operating costs	7,525	6,567	7,173	7,295	7,639
Merger termination fee and related costs, net	—	(936)	104	23	—
Depreciation and amortization	405	378	354	355	333
Total operating expenses	53,812	49,505	52,638	51,942	46,138
Income from operations	3,100	4,262	1,741	2,347	2,362
Loss (gain) on sale of business	786	—	—	(270)	—
Interest expense	218	242	189	186	192
Other expense, net	33	—	—	—	—
Income before income taxes and equity in net earnings	2,063	4,020	1,552	2,431	2,170
Provision for income taxes	391	1,572	938	1,155	1,023
Equity in net earnings of Kindred at Home	11	—	—	—	—
Net income	$ 1,683	$ 2,448	$ 614	$ 1,276	$ 1,147
Basic earnings per common share	$ 12.24	$ 16.94	$ 4.11	$ 8.54	$ 7.44
Diluted earnings per common share	$ 12.16	$ 16.81	$ 4.07	$ 8.44	$ 7.36
Dividends declared per common share	$ 2.00	$ 1.60	$ 1.16	$ 1.15	$ 1.11
Financial Position:					
Cash and investments	$ 12,780	$ 16,344	$ 13,675	$ 11,681	$ 11,482
Total assets	25,413	27,178	25,396	24,678	23,497
Benefits payable	4,862	4,668	4,563	4,976	4,475
Debt	6,069	4,920	4,092	4,093	3,795
Stockholders' equity	10,161	9,842	10,685	10,346	9,646
Cash flows from operations	$ 2,173	$ 4,051	$ 1,936	$ 868	$ 1,618
Key Financial Indicators:					
Benefit ratio	83.5%	83.0%	84.9%	84.5%	83.0%
Operating cost ratio	13.3%	12.3%	13.3%	13.6%	15.9%
Membership by Segment:					
Retail segment:					
Medical membership	9,161,500	9,206,300	8,751,300	8,327,700	7,360,300
Group and Specialty segment:					
Medical membership	7,415,200	4,638,200	4,793,300	4,963,400	5,430,200
Specialty membership	6,072,300	6,986,000	6,961,200	7,221,800	7,668,500
Individual commercial segment:					
Medical membership	—	128,800	654,800	899,100	1,016,200
Other Businesses:					
Medical membership	—	29,800	30,800	32,600	35,000
Consolidated:					
Total medical membership	16,576,700	14,003,100	14,230,200	14,222,800	13,841,700
Total specialty membership	6,072,300	6,986,000	6,961,200	7,221,800	7,668,500

(a) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies, which were sold in 2018.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, excluding Merger termination fee and related costs, net, and depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

Business Segments

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes our services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our investment in Kindred at Home. The Individual Commercial segment consisted of our individual commercial fully-insured medical health insurance business, which we exited beginning January 1, 2018. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies, which were sold in 2018.

The results of each segment are measured by income before income taxes and equity in net earnings from Kindred at Home, or segment earnings. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and

certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare marketing season.

Our Group and Specialty segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group and Specialty segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses.

Aetna Merger

On February 16, 2017, under the terms of the Agreement and Plan of Merger, or Merger Agreement, with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned "Merger termination fee and related costs, net."

Acquisitions and Divestitures

On August 9, 2018, we completed the sale of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit. Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

On July 2, 2018 and July 11, 2018, we along with TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS, collectively, the Sponsors, completed the acquisitions of Kindred and Curo, respectively, merging Curo with the hospice business of Kindred at Home. As part of these transactions, we acquired a 40% minority interest in the combined business, Kindred at Home, a for total cash consideration of approximately $1.1 billion.

On April 10, 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG is one of the largest at-risk providers serving Medicare Advantage and Managed

Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties.

On March 1, 2018, we acquired the remaining equity interest in MCCI Holdings LLC, or MCCI, a privately held management service organization headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million.

These transactions are more fully discussed in Note 3 to the consolidated financial statements.

Highlights

Consolidated

- Our 2018 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2018, approximately 2,039,100 members, or 67%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,901,300 members, or 66%, at December 31, 2017.
- Our consolidated pretax income was $2.06 billion for 2018 compared to $4.02 billion in 2017. A number of significant items effected our year-over-year comparisons including the following:
    - The net gain associated with the terminated Merger Agreement, mainly the break-up fee of $936 million in 2017.
    - The loss on sale of KMG of $786 million in 2018.
    - Charges in 2017 of $219 million associated with voluntary and involuntary workforce reduction programs, the Penn Treaty guaranty fund assessment and costs associated with the early retirement of debt.
    - Lower year-over-year segment earnings in our Retail, Group and Specialty and Healthcare Services segments reflects the impact of investing the benefit of a lower tax rate from the 2017 Tax Reform Law into the establishment of an annual incentive compensation program for a broader range of employees, together with additional investments in the communities of our members, technology and our integrated care delivery model to drive more affordable healthcare and better clinical outcomes.
    - Our year-over-year pretax comparisons were also favorably impacted by strong Medicare Advantage membership growth and operating efficiencies from productivity initiatives implemented in 2017. These increases were partially offset by enhanced 2018 Medicare Advantage benefits resulting from investing the better than expected 2017 individual Medicare Advantage pretax earnings, coupled with the return of the health insurance industry fee, and a more severe flu season in 2018.
- Year-over-year comparisons of diluted earnings per common share were also favorably impacted by a lower number of shares used to compute earnings per common share from share repurchases and the impact of a lower tax rate for the year ended December 31, 2018.The 2017 Tax Reform Law coupled with the tax benefit

from the sale of KMG, partially offset by return of the nondeductible health insurance industry fee, drove the lower tax rate in 2018.

- We returned capital to our shareholders in the form of increased shareholder dividends and significant share repurchase. In 2018, we increased our per share dividend by 25% and repurchased shares worth approximately $1.1 billion, including the accelerated share repurchase agreement, or ASR, that we entered into in November 2018.

- The annual health insurance industry fee was suspended for calendar year 2017, but resumed in 2018. Operating costs associated with the health insurance industry fee attributable to 2018 were $1.04 billion paid in October 2018. This fee is not deductible for tax purposes, which increases our effective income tax rate. The one-year suspension in 2017 of the health insurance industry fee significantly reduced our operating costs and effective tax rate during 2017. The annual health insurance industry fee is also suspended for calendar year 2019, but under current law is scheduled to resume for calendar year 2020.

Retail Segment

- Individual and Group Medicare Advantage membership increased 259,600 members, or 7.9%, in 2018 to 3,561,800 members December 31, 2018.

- On January 30, 2019, after the stock market closed, the Centers for Medicare and Medicaid Services (CMS) issued its preliminary 2020 Medicare Advantage and Part D payment rates and proposed policy changes (collectively, the Advance Notice). CMS has invited public comment on the Advance Notice before publishing final rates on April 1, 2019 (the Final Notice). In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 1.59 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS' website, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate. We will be drawing upon our program expertise to provide CMS formal commentary on the impact of the Advance Notice and the related impact upon Medicare beneficiaries' quality of care and service to our members through the Medicare Advantage program.

- On April 24, 2018, we received a Notice of Intent to be Awarded a Comprehensive Medicaid Contract under Florida's Statewide Managed Medicaid Program in all 11 regions, including the South Florida, Tampa, Jacksonville, and Orlando metro areas. The comprehensive program combines the traditional Medicaid, or TANF, and Long-Term Care programs. Phase-in under the new contract began December 2018 and was fully implemented February 1, 2019.

- In October 2018, CMS published its updated Star quality ratings for bonus year 2020. We received a 5-star rating on CMS' 5-star rating system for two MA contracts offered in Florida and Tennessee. In addition, we received a 4.5-star rating for two MA contracts offered in Florida, Illinois, Kentucky, Mississippi, North Carolina, and Oregon. We have 12 contracts rated 4-star or above and 3 million members in 4-star or above rated contracts to be offered in 2019, representing 84% of our MA membership as of July 2018. The achievement of a 5-star rating for two MA contracts in Florida and Tennessee provides us the ability to market for these contracts throughout the year, creating an opportunity for increased penetration in these important geographies. We cannot guarantee, however, our ability to maintain or improve our star ratings.

Group and Specialty Segment

- During 2018, we transitioned to the new, larger T2017 East Region contract increasing membership 2,846,800 or 92.4%.The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set

to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Healthcare Services Segment

- We continued to invest in our Healthcare Services segment necessary to drive effective care delivery and clinical outcomes with our acquisitions of MCCI and FPG and our 40% investment in Kindred at Home.
- Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 716,000 at December 31, 2018, a decrease of 9.9% from 794,900 at December 31, 2017. These members may not be unique to each program since members have the ability to enroll in multiple programs. We have undergone an optimization process that ensures the appropriate level of member interaction with clinicians to drive quality outcomes, which has resulted in improved Retail segment operating results.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee levied on the insurance industry is $14.3 billion in 2018 and is not deductible for income tax purposes, which significantly increases our effective income tax rate. A one year suspension of the health insurance industry fee, as we experienced in 2017 and are experiencing in 2019, significantly impacts our trend in key operating metrics including our operating cost and medical expense ratios, as well as our effective tax rate. The annual health insurance industry fee is scheduled to resume for calendar year 2020 under current law.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Although we previously participated in these exchanges by offering on-exchange individual commercial medical plans, effective January 1, 2018, we have exited our Individual Commercial medical business.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016. Our case has been stayed by the Court, pending resolution of similar cases filed by other insurers.

It is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative, judicial or regulatory changes, including restrictions on our ability to manage our provider network or otherwise operate our business, or restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and

clinical care services, to our Retail and Group and Specialty segment customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2018 Form 10-K.

Comparison of Results of Operations for 2018 and 2017

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2018 and 2017:

Consolidated

	2018	2017	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 48,108	$ 44,626	$ 3,482	7.8 %
Group and Specialty	6,803	6,772	31	0.5 %
Individual Commercial	8	947	(939)	(99.2)%
Other Businesses	22	35	(13)	(37.1)%
Total premiums	54,941	52,380	2,561	4.9 %
Services:				
Retail	11	10	1	10.0 %
Group and Specialty	835	626	209	33.4 %
Healthcare Services	607	338	269	79.6 %
Other Businesses	4	8	(4)	(50.0)%
Total services	1,457	982	475	48.4 %
Investment income	514	405	109	26.9 %
Total revenues	56,912	53,767	3,145	5.8 %
Operating expenses:				
Benefits	45,882	43,496	2,386	5.5 %
Operating costs	7,525	6,567	958	14.6 %
Merger termination fee and related costs, net	—	(936)	936	(100.0)%
Depreciation and amortization	405	378	27	7.1 %
Total operating expenses	53,812	49,505	4,307	8.7 %
Income from operations	3,100	4,262	(1,162)	(27.3)%
Loss on sale of business	786	—	786	100.0 %
Interest expense	218	242	(24)	(9.9)%
Other expense, net	33	—	33	100.0 %
Income before income taxes and equity in net earnings	2,063	4,020	(1,957)	(48.7)%
Provision for income taxes	391	1,572	(1,181)	(75.1)%
Equity in net earnings of Kindred at Home	11	—	11	100.0 %
Net income	$ 1,683	$ 2,448	$ (765)	(31.3)%
Diluted earnings per common share	$ 12.16	$ 16.81	$ (4.65)	(27.7)%
Benefit ratio (a)	83.5%	83.0%		0.5 %
Operating cost ratio (b)	13.3%	12.3%		1.0 %
Effective tax rate	18.9%	39.1%		(20.2)%

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income for 2018 was $1.7 billion, or $12.16 per diluted common share compared to $2.4 billion, or $16.81 per diluted common share, in 2017. This comparison was impacted by the loss on sale of KMG in 2018, the Merger Agreement break-up fee in 2017, the suspension of the health insurance industry fee for calendar year 2017, the exit out of the Individual Commercial business effective January 1, 2018, a lower tax rate due to the Tax Reform Law, charges associated with both voluntary and involuntary workforce reduction programs in 2017, and the estimated guaranty fund assessment expense to support the policyholders obligation of Penn Treaty in 2017. After consideration of these items, our earnings were favorably impacted by strong Medicare Advantage membership growth and significant operating efficiencies in 2018 driven by productivity initiatives implemented in 2017. These increases were partially offset by our offering of enhanced 2018 Medicare Advantage member benefits which resulted from the investment of the better than expected 2017 individual Medicare Advantage pretax earnings, coupled with the return of the health insurance industry fee and the more severe flu season during the first quarter of 2018.The comparison of diluted earnings per common share are also impacted by a lower number of shares from share repurchases.

Premiums Revenue

Consolidated premiums increased $2.6 billion, or 4.9%, from $52.4 billion for 2017 to $54.9 billion for 2018 primarily driven by higher Medicare Advantage revenues, partially offset by the impact of lower revenues from the exit of the Individual Commercial business.

Services Revenue

Consolidated services revenue increased $475 million, or 48.4%, from $982 million for 2017 to $1.5 billion for 2018, primarily due to an increase in services revenue in the Healthcare Services and Group and Specialty segments, as discussed in the detailed segment results discussion that follows.

Investment Income

Investment income was $514 million for 2018, increasing $109 million, or 26.9%, from 2017, primarily due to higher realized capital gains and higher interest rates in 2018, partially offset by lower average invested balances.

Benefits Expense

Consolidated benefits expense was $45.9 billion for 2018, an increase of $2.4 billion, or 5.5%, from 2017 reflecting an increase in the Retail and Group and Specialty segments benefits expense as discussed in the detailed segment results discussion that follows. These increases were partially offset by a decrease in the Individual Commercial segment benefits expense. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $503 million in 2018 and $483 million in 2017.

The consolidated benefit ratio for 2018 was 83.5%, an increase of 50 basis points from 2017 primarily due to the enhanced 2018 Medicare Advantage member benefits resulting from the investment of the better than expected 2017 individual Medicare Advantage pretax earnings and a more severe flu season in the first quarter of 2018. These items were partially offset by the positive impact from the reinstatement of the health insurance industry fee in 2018, which was contemplated in the pricing and benefit design of our products and higher favorable prior-period reserve development. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 90 basis points in both 2018 and 2017.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs increased $958 million, or 14.6%, from 2017 to $7.5 billion in 2018 reflecting an increase in the Retail and Group and Specialty segments discussed in the detailed segment results discussion that follows. These increases were partially offset by a decrease in the Individual Commercial segment operating costs.

The consolidated operating cost ratio for 2018 was 13.3%, increasing 100 basis points from 12.3% in 2017 primarily due to the reinstatement of the health insurance industry fee in 2018, and long term sustainability investments made in 2018 as a result of the Tax Reform Law. Our long-term sustainability investments include the continuation of investments in our associate workforce, primarily the establishment of an annual incentive program for a broader range of employees, together with additional investments in the communities of our members, technology and our integrated care delivery model to drive more affordable healthcare and better clinical outcomes, and an increase in incentive compensation costs under the expanded program noted above. The ratio was further impacted by the growth in our military services business, which carries a higher operating ratio than our other products, due to the previously disclosed transition to the T2017 East Region contract effective January 1, 2018. These items were partially offset by the favorable impact of significant operating cost efficiencies in 2018 driven by productivity initiatives implemented in 2017, the impact of the charges recorded in 2017 associated with the voluntary and involuntary workforce reduction program, and the favorable year-over-year comparison of the impact of the guaranty fund assessment expense to support policyholder obligations of Penn Treaty in 2017, as well as the exit of the Individual Commercial business effective January 1, 2018, which carried a higher operating cost ratio than our other products. The nondeductible health insurance industry fee impacted the operating cost ratio by approximately 180 basis points in 2018.

Depreciation and Amortization

Depreciation and amortization in 2018 totaled $405 million compared to $378 million in 2017, an increase of 7.1%, primarily due to capital expenditures, the acquisitions of MCCI and FPG, and the write-off of a trade name value reflecting the re-branding of certain provider assets.

Interest Expense

Interest expense was $218 million for 2018 compared to $242 million for 2017, a decrease of $24 million, or 9.9%, primarily as a result of the early redemption of higher rate debt in December 2017.

Income Taxes

Our effective tax rate during 2018 was 18.9% compared to the effective tax rate of 39.1% in 2017. This decrease is primarily due to the Tax Reform Law and the tax benefit resulting from the sale of KMG, partially offset by the impact of the reinstatement of the non-deductible health insurance industry fee in 2018. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

	2018	2017	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	3,064,000	2,860,800	203,200	7.1 %
Group Medicare Advantage	497,800	441,400	56,400	12.8 %
Medicare stand-alone PDP	5,004,300	5,308,100	(303,800)	(5.7)%
Total Retail Medicare	8,566,100	8,610,300	(44,200)	(0.5)%
State-based Medicaid	341,100	360,100	(19,000)	(5.3)%
Medicare Supplement	254,300	235,900	18,400	7.8 %
Total Retail medical members	9,161,500	9,206,300	(44,800)	(0.5)%

	2018	2017	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 35,656	$ 32,720	$ 2,936	9.0 %
Group Medicare Advantage	6,103	5,155	948	18.4 %
Medicare stand-alone PDP	3,584	3,702	(118)	(3.2)%
Total Retail Medicare	45,343	41,577	3,766	9.1 %
State-based Medicaid	2,255	2,571	(316)	(12.3)%
Medicare Supplement	510	478	32	6.7 %
Total premiums	48,108	44,626	3,482	7.8 %
Services	11	10	1	10.0 %
Total premiums and services revenue	$ 48,119	$ 44,636	$ 3,483	7.8 %
Segment earnings	$ 1,733	$ 1,978	$ (245)	(12.4)%
Benefit ratio	85.1%	85.6%		(0.5)%
Operating cost ratio	11.1%	9.6%		1.5 %

Segment Earnings

- Retail segment earnings were $1.7 billion in 2018, a decrease of $245 million, or 12.4%, compared to 2017 reflecting a higher operating cost ratio in 2018, partially offset by a lower benefit ratio.

Enrollment

- Individual Medicare Advantage membership increased 203,200 members, or 7.1%, from December 31, 2017 to December 31, 2018 reflecting net membership additions associated with last year's Annual Election Period, or AEP, for Medicare beneficiaries. For full year 2019, we anticipate net membership growth in our individual Medicare Advantage offerings of 375,000 to 400,000.
- Group Medicare Advantage membership increased 56,400 members, or 12.8%, from December 31, 2017 to December 31, 2018 reflecting increased sales to our existing group accounts during last year's AEP for Medicare beneficiaries. For full year 2019, we anticipate net membership growth in our group Medicare Advantage offerings of approximately 30,000.

- Medicare stand-alone PDP membership decreased 303,800 members, or 5.7%, from December 31, 2017 to December 31, 2018 reflecting net declines during last year's AEP for Medicare beneficiaries. These declines primarily resulted from the previously disclosed loss of auto assigned members in Florida and South Carolina due to pricing over the CMS low income benchmark and continued membership declines in our Enhanced Plan. In addition, growth in our co-branded Walmart plan was significantly lower than historical levels due to the introduction of additional low-priced competitor offerings in many regions. For the full year 2019, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of 700,000 to 750,000.

- State-based Medicaid membership decreased 19,000 members, or 5.3%, from December 31, 2017 to December 31, 2018, primarily driven by our election not to participate in Illinois' Medicaid Integrated Care Program and the Virginia Long Term Support Services contract that replaced the state's previous stand-alone dual eligible demonstration program in December 2017. Year-over-year decline was also impacted by lower membership associated with our Florida Medicaid contract due to overall strengthening economic conditions, partially offset by the addition of members associated with the new Florida Managed Medical Assistance program from the contract phase-in for certain regions that began December 1, 2018.

Premiums revenue

- Retail segment premiums increased $3.5 billion, or 7.8%, from 2017 to 2018 primarily reflecting individual and group Medicare Advantage membership growth in last year's AEP as well as increased per-member premiums for certain of the segment's products, partially offset by declines in stand-alone PDP and state-based contracts revenues resulting from year-over-year membership declines discussed above. Average group and individual Medicare Advantage membership increased 7.6% in 2018. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per-member premiums. Items impacting average per-member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Benefits expense

- The Retail segment benefit ratio of 85.1% for 2018 decreased 50 basis points from 2017 primarily due to the reinstatement of the non-deductible health insurance industry fee in 2018 which was contemplated in the pricing and benefit design of our products, partially offset by the unfavorable impact from enhanced 2018 Medicare Advantage member benefits resulting from the investment of the better than expected 2017 individual Medicare Advantage pretax earnings. 2018 was also impacted by a more severe flu season.

- The Retail segment’s benefits expense for 2018 included the beneficial effect of $398 million in favorable prior-year medical claims reserve development versus $386 million in 2017. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 80 basis points in 2018 versus approximately 90 basis points in 2017.

Operating costs

- The Retail segment operating cost ratio of 11.1% for 2018 increased 150 basis points from 2017 primarily due to the reinstatement of the health insurance industry fee in 2018 and increase in incentive compensation costs under the expanded program, resulting from the strategic investments made in 2018 as a result of the Tax Reform Law. These items were partially offset by significant operating cost efficiencies in 2018 driven by productivity initiatives implemented in 2017.

- The non-deductible health insurance industry fee increased the operating cost ratio by approximately 190 basis points in 2018.

Group and Specialty Segment

	2018	2017	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,004,700	1,097,700	(93,000)	(8.5)%
ASO	481,900	458,700	23,200	5.1 %
Military services	5,928,600	3,081,800	2,846,800	92.4 %
Total group medical members	7,415,200	4,638,200	2,777,000	59.9 %
Specialty membership (a)	6,072,300	6,986,000	(913,700)	(13.1)%

(a) Specialty products include dental, vision, voluntary benefit products and other supplemental health benefits and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2018	2017	Change Dollars	Change Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,444	$ 5,462	$ (18)	(0.3)%
Specialty	1,359	1,310	49	3.7 %
Total premiums	6,803	6,772	31	0.5 %
Services	835	626	209	33.4 %
Total premiums and services revenue	$ 7,638	$ 7,398	$ 240	3.2 %
Segment earnings	$ 361	$ 412	$ (51)	(12.4)%
Benefit ratio	79.7%	79.2%		0.5 %
Operating cost ratio	23.6%	21.4%		2.2 %

Segment Earnings

- Group and Specialty segment earnings were $361 million in 2018, a decrease of $51 million, or 12.4%, from $412 million in 2017 primarily reflecting higher benefit and operating cost ratios in 2018, partially offset by a favorable year-over-year earnings comparison for our group ASO commercial medical business.

Enrollment

- Fully-insured commercial group medical membership decreased 93,000 members, or 8.5% from December 31, 2017 primarily reflecting lower membership in small group accounts due in part to more small group accounts selecting level-funded ASO products in 2018. The portion of group fully-insured commercial medical membership in small group accounts was approximately 61% at December 31, 2018 and 64% at December 31, 2017.
- Group ASO commercial medical membership increased 23,200 members, or 5.1%, from December 31, 2017 to December 31, 2018 reflecting more small group accounts selecting level-funded ASO products in 2018, partially offset by the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.
- Specialty membership decreased 913,700 members, or 13.1%, from December 31, 2017 to December 31, 2018 primarily resulted from the exit of our voluntary benefits and financial protection lines of business in connection

with the sale of KMG, as well as the loss of some large group accounts offering stand-alone dental and vision products. These decreases were partially offset by an increase in individual dental and vision membership.

Premiums revenue

- Group and Specialty segment premiums increased $31 million, or 0.5%, from 2017 to 2018 primarily due to higher stop-loss premiums related to our level funded ASO accounts resulting from membership growth in this product, and higher per-member premiums across the commercial fully-insured business, partially offset by the exit of our voluntary benefits and financial protection lines of business in connection with the sale of KMG, as well as declines in average group fully-insured commercial medical membership.

Services revenue

- Group and Specialty segment services revenue increased $209 million, or 33.4%, from 2017 to 2018 as a result of the transition to the TRICARE T2017 East Region contract on January 1, 2018.

Benefits expense

- The Group and Specialty segment benefit ratio increased 50 basis points from 79.2% in 2017 to 79.7% in 2018 primarily due to retroactive contractual rate adjustments, membership mix, including the continued migration of healthier groups to level funded ASO products in 2018, and the impact of the exit of our voluntary benefits and financial protection lines of business in connection with the sale of KMG, which carried a very low benefit ratio. These factors were partially offset by the reinstatement of the health insurance industry fee in 2018 which was contemplated in the pricing of our products, and higher favorable prior-period reserve development.

- The Group and Specialty segment's benefits expense included the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2018 versus $40 million in 2017. This favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2018 versus approximately 60 basis points in 2017.

Operating costs

- The Group and Specialty segment operating cost ratio of 23.6% for 2018 increased 220 basis points from 21.4% for 2017. These increases primarily were due to the reinstatement of the health insurance industry fee in 2018, growth in our military services business, which carries a higher operating cost ratio than other products within the segment, as a result of the transition to the TRICARE T2017 East Region contract, an increase in incentive compensation costs under the expanded program resulting from the strategic investments made in 2018 as a result of the Tax Reform Law. These items were partially offset by significant operating cost efficiencies driven by productivity initiatives implemented in 2017, and the impact of the exit of our voluntary benefits and financial protection lines of business in connection with the sale of KMG. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2018.

Healthcare Services Segment

	2018	2017	Change Dollars	Change Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 176	$ 181	$ (5)	(2.8)%
Pharmacy solutions	203	80	123	153.8 %
Provider services	228	77	151	196.1 %
Total services revenues	607	338	269	79.6 %
Intersegment revenues:				
Pharmacy solutions	20,514	20,881	(367)	(1.8)%
Provider services	1,994	1,593	401	25.2 %
Clinical care services	662	1,111	(449)	(40.4)%
Total intersegment revenues	23,170	23,585	(415)	(1.8)%
Total services and intersegment revenues	$ 23,777	$ 23,923	$ (146)	(0.6)%
Segment earnings	$ 754	$ 967	$ (213)	(22.0)%
Operating cost ratio	96.3%	95.5%		0.8 %

Segment Earnings

- Healthcare Services segment earnings were $754 million in 2018, a decrease of $213 million, or 22.0%, from 2017 primarily due to the impact of the optimization process associated with our chronic care management programs and investments made in 2018 as a result of the Tax Reform Law, partially offset by the impact of Kindred at Home.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 440 million in 2018, up 2% versus scripts of approximately 433 million in 2017. The increase primarily reflects growth associated with higher Individual Advantage Medicare membership, partially offset by the decline in stand-alone PDP and Individual Commercial membership.

Services revenue

- Services revenue increased $269 million, or 79.6%, from 2017 to $607 million for 2018 primarily due to service revenue growth from our provider services and pharmacy solutions business.

Intersegment revenues

- Intersegment revenues decreased $415 million, or 1.8%, from 2017 to $23.2 billion for 2018 primarily due to a decline in pharmacy solutions revenue due to lower stand-alone PDP membership, the loss of intersegment revenues associated with our exit from the Individual commercial business, the result of improving the effectiveness of our chronic care management programs, and the impact to our provider services business of the lower Medicare rates year-over-year in geographies where our provider assets are primarily located. These declines were partially offset by Medicare Advantage membership growth as well as higher intersegment revenues associated with our provider services business reflecting our acquisition of MCCI.

Operating costs

- The Healthcare Services segment operating cost ratio of 96.3% for 2018 increased from 95.5% for 2017 primarily due to an increase in incentive compensation costs under the expanded program resulting from the strategic investments made in 2018 as a result of the Tax Reform Law and the lag in operating cost reduction associated with improving the effectiveness of our chronic care management programs as compared to the timing of reduction in revenue. These items were partially offset by significant operating cost efficiencies in 2018 driven by productivity initiatives implemented in 2017.

Individual Commercial Segment

- In 2018, our Individual Commercial segment pretax income was $74 million, a decrease of $119 million, from a pretax income of $193 million in 2017 primarily due to the impact of favorable prior-period reserve development from the run-out of this business. We exited this business effective January 1, 2018.

Other Businesses

As previously disclosed, in the third quarter of 2018, we completed the sale of our wholly-owned subsidiary KMG, as discussed further in Note 3 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2018 Form 10-K.

Comparison of Results of Operations for 2017 and 2016

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2017 and 2016:

Consolidated

	2017	2016	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 44,626	$ 43,223	$ 1,403	3.2 %
Group and Specialty	6,772	6,696	76	1.1 %
Individual Commercial	947	3,064	(2,117)	(69.1)%
Other Businesses	35	38	(3)	(7.9)%
Total premiums	52,380	53,021	(641)	(1.2)%
Services:				
Retail	10	6	4	66.7 %
Group and Specialty	626	643	(17)	(2.6)%
Healthcare Services	338	310	28	9.0 %
Other Businesses	8	10	(2)	(20.0)%
Total services	982	969	13	1.3 %
Investment income	405	389	16	4.1 %
Total revenues	53,767	54,379	(612)	(1.1)%
Operating expenses:				
Benefits	43,496	45,007	(1,511)	(3.4)%
Operating costs	6,567	7,173	(606)	(8.4)%
Merger termination fee and related costs, net	(936)	104	(1,040)	(1,000.0)%
Depreciation and amortization	378	354	24	6.8 %
Total operating expenses	49,505	52,638	(3,133)	(6.0)%
Income from operations	4,262	1,741	2,521	144.8 %
Interest expense	242	189	53	28.0 %
Income before income taxes	4,020	1,552	2,468	159.0 %
Provision for income taxes	1,572	938	634	67.6 %
Net income	$ 2,448	$ 614	$ 1,834	298.7 %
Diluted earnings per common share	$ 16.81	$ 4.07	$ 12.74	313.0 %
Benefit ratio (a)	83.0%	84.9%		(1.9)%
Operating cost ratio (b)	12.3%	13.3%		(1.0)%
Effective tax rate	39.1%	60.5%		(21.4)%

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income was $2.4 billion, or $16.81 per diluted common share, in 2017 compared to $614 million, or $4.07 per diluted common share, in 2016. Net income in 2017 includes a net gain of $4.31 per diluted common share associated with the terminated Merger Agreement consisting primarily of the break-up fee, and the beneficial effect of the lower effective tax rate in light of pricing and benefit design assumptions with the temporary suspension of the health insurance industry fee of $2.15 per diluted common share, excluding the Individual Commercial business impact. The year-over-year comparison was also favorably impacted by a write-off of $2.43 per diluted common share in receivables associated with the commercial risk corridor premium stabilization program, and the reserve strengthening for our non-strategic closed block of long-term care insurance business of $2.11 per common diluted share recorded in 2016. These items were partially offset by the impact of the tax reform law enacted on December 22, 2017, or the Tax Reform Law, which resulted in the reduction of our net income due to the remeasurement of deferred tax assets at lower enacted corporate tax rates of $0.92 per diluted common share, $0.64 per common diluted share in charges associated with both voluntary and involuntary workforce reduction programs in 2017, as well as the estimated guaranty fund assessment expense to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company) of $0.24 per diluted common share. Excluding the impacts of the items above, the increase in net income primarily was due to year-over-year improvements in earnings for our Individual Commercial, Retail, and Group and Specialty segments, partially offset by lower earnings in the Healthcare Services segment.

Premiums Revenue

Consolidated premiums decreased $641 million, or 1.2%, from 2016 to $52.4 billion for 2017 primarily due to lower premiums in the Individual Commercial segment, partially offset by higher premiums in the Retail segment, primarily resulting from growth in our Medicare Advantage business, and higher premiums in the Group and Specialty segment, as discussed in the detailed segment results discussion that follows.

Services Revenue

Consolidated services revenue increased $13 million, or 1.3%, from 2016 for 2017 primarily due to an increase in services revenue in the Healthcare Services segment, partially offset by a decrease in services revenue in the Group and Specialty segment as discussed in the detailed segment results discussion that follows.

Investment Income

Investment income totaled $405 million for 2017, increasing $16 million, or 4.1%, from 2016, primarily due to higher average invested balances and interest rates in 2017, partially offset by lower realized capital gains.

Benefits Expense

Consolidated benefits expense was $43.5 billion for 2017, a decrease of $1.5 billion, or 3.4%, from 2016 reflecting $505 million in incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies recorded in 2016. Excluding the long-term care reserve strengthening in 2016, the decrease primarily was due to a decrease in the Individual Commercial segment benefits expense, partially offset by an increase in the Retail and Group and Specialty segments benefits expense as discussed in the detailed segment results discussion that follows. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017 and $582 million in 2016.

The consolidated benefit ratio for 2017 was 83.0%, a decrease of 190 basis points from 2016 primarily due to the incremental benefits expense in 2016 for the reserve strengthening in our non-strategic closed block of long-term care insurance policies. Excluding the impact of the above, the decrease in the consolidated benefit ratio primarily was due to the decrease in the Individual Commercial segment benefit ratio, partially offset by the increase in the Retail and Group and Specialty segment benefit ratio as discussed in the segment results of operation discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 90 basis points in 2017 versus approximately 110 basis points in 2016.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs decreased $606 million, or 8.4%, from 2016 to $6.6 billion in 2017 primarily due to the temporary suspension of the health insurance industry fee for the calendar year 2017 and lower Individual Commercial membership. This was partially offset by charges associated with both voluntary and involuntary workforce reduction programs, an increase in employee compensation costs resulting from the continued strong performance, increased spending associated with the Medicare Annual Election Period, or AEP, as well as the estimated guaranty fund assessment expense recorded to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company).

The consolidated operating cost ratio for 2017 was 12.3%, decreasing 100 basis points from 2016 primarily due to the temporary suspension of the health insurance industry fee for the calendar year 2017, the write-off of receivables associated with the commercial risk corridor premium stabilization program in 2016, as well as operating cost efficiencies, partially offset by the loss of scale efficiency from market exits in the 2017 period associated with the Individual Commercial product, the estimated charges associated with both voluntary and involuntary workforce reduction programs recorded in 2017, increased employee compensation costs resulting from the continued strong performance, as well as the impact of the estimated guaranty fund assessment expense recorded to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company). The non-deductible health insurance industry fee impacted the operating cost ratio by 170 basis points in 2016.

Depreciation and Amortization

Depreciation and amortization for 2017 of $378 million was relatively unchanged from 2016.

Interest Expense

Interest expense was $242 million for 2017 compared to $189 million for 2016, an increase of $53 million, or 28.0% due to the issuance of $1.8 billion in senior notes, a portion of the proceeds which were used to redeem $800 million of senior notes scheduled to mature in 2018. We recognized a loss on extinguishment of debt of approximately $17 million in December 2017 for the redemption of these senior notes, which is included in interest expense.

Income Taxes

Our effective tax rate during 2017 was 39.1% compared to the effective tax rate of 60.5% in 2016 primarily reflecting the suspension of the annual health insurance industry fee in 2017, as well as previously non-deductible transaction costs that, as a result of termination of the Merger Agreement, became deductible for tax purposes and were recorded as such in the first quarter of 2017, partially offset by the Tax Reform Law, which increased our effective tax rate due to the remeasurement of deferred tax assets at lower enacted corporate tax rates. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

	2017	2016	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,860,800	2,837,600	23,200	0.8 %
Group Medicare Advantage	441,400	355,400	86,000	24.2 %
Medicare stand-alone PDP	5,308,100	4,951,400	356,700	7.2 %
Total Retail Medicare	8,610,300	8,144,400	465,900	5.7 %
State-based Medicaid	360,100	388,100	(28,000)	(7.2)%
Medicare Supplement	235,900	218,800	17,100	7.8 %
Total Retail medical members	9,206,300	8,751,300	455,000	5.2 %

	2017	2016	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 32,720	$ 31,863	$ 857	2.7 %
Group Medicare Advantage	5,155	4,283	872	20.4 %
Medicare stand-alone PDP	3,702	4,009	(307)	(7.7)%
Total Retail Medicare	41,577	40,155	1,422	3.5 %
State-based Medicaid	2,571	2,640	(69)	(2.6)%
Medicare Supplement	478	$ 428	50	11.7 %
Total premiums	44,626	43,223	1,403	3.2 %
Services	10	6	4	66.7 %
Total premiums and services revenue	$ 44,636	$ 43,229	$ 1,407	3.3 %
Segment earnings	$ 1,978	$ 1,690	$ 288	17.0 %
Benefit ratio	85.6%	85.1%		0.5 %
Operating cost ratio	9.6%	10.8%		(1.2)%

Segment Earnings

- Retail segment earnings were $2.0 billion in 2017, an increase of $288 million, or 17.0%, compared to 2016 primarily driven by the year-over-year improvement in our Medicare Advantage business.

Enrollment

- Individual Medicare Advantage membership increased 23,200 members, or 0.8%, from December 31, 2016 to December 31, 2017 reflecting net membership additions for Medicare beneficiaries including the effect of planned market and product exits in 2017. We decided certain markets and/or products were not meeting long term strategic and financial objectives. Additionally, membership growth was muted due to competitive actions including the uncertainty associated with the then-pending Merger transaction during last year's AEP.

- Group Medicare Advantage membership increased 86,000 members, or 24.2%, from December 31, 2016 to December 31, 2017 reflecting the addition of a large account in January 2017.

- Medicare stand-alone PDP membership increased 356,700 members, or 7.2%, from December 31, 2016 to December 31, 2017 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2017 plan year.

- State-based Medicaid membership decreased 28,000 members, or 7.2%, from December 31, 2016 to December 31, 2017 primarily driven by lower membership associated with our Florida contracts resulting from network realignments.

Premiums revenue

- Retail segment premiums increased $1.4 billion, or 3.2%, from 2016 to 2017 primarily due to Medicare Advantage membership growth and increased per-member premiums for certain of the segment's products. Average group and individual Medicare Advantage membership increased 3.4% in 2017. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per-member premiums. Items impacting average per-member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Benefits expense

- The Retail segment benefit ratio of 85.6% for 2017 increased 50 basis points from 2016 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing and benefit design of our products, margin compression associated with the competitive environment in the group Medicare Advantage business and slightly lower favorable prior-period medical claims reserve development. These increases were partially offset by the impact of planned exits from certain Medicare Advantage markets that carried a higher benefit ratio than other markets as well as lower than expected medical costs as compared to the assumptions used in the pricing of our individual Medicare Advantage business.

- The Retail segment's benefits expense for 2017 included the beneficial effect of $386 million in favorable prior-year medical claims reserve development versus $429 million in 2016. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 90 basis points in 2017 versus approximately 100 basis points in 2016.

Operating costs

- The Retail segment operating cost ratio of 9.6% for 2017 decreased 120 basis points from 2016 primarily due to the temporary suspension of the health insurance industry fee for calendar year 2017, partially offset by increased spending associated with AEP, investments in our integrated care delivery model, and the increase in employee compensation costs resulting from the continued strong performance. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016.

Group and Specialty Segment

	2017	2016	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,097,700	1,136,000	(38,300)	(3.4)%
ASO	458,700	573,200	(114,500)	(20.0)%
Military services	3,081,800	3,084,100	(2,300)	(0.1)%
Total group medical members	4,638,200	4,793,300	(155,100)	(3.2)%
Specialty membership (a)	6,986,000	6,961,200	24,800	0.4 %

(a) Specialty products include dental, vision, voluntary benefit products and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2017	2016	Change Dollars	Change Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,462	$ 5,405	$ 57	1.1 %
Specialty	1,310	1,279	31	2.4 %
Military services	—	12	(12)	(100.0)%
Total premiums	6,772	6,696	76	1.0 %
Services	626	643	(17)	(2.6)%
Total premiums and services revenue	$ 7,398	$ 7,339	$ 59	0.8 %
Income before income taxes	$ 412	$ 344	$ 68	19.8 %
Benefit ratio	79.2%	78.2%		1.0 %
Operating cost ratio	21.4%	23.5%		(2.1)%

Segment Earnings

- Group and Specialty segment earnings were $412 million in 2017, an increase of $68 million, or 19.8%, from $344 million in 2016 primarily reflecting the impact of higher pretax earnings associated with our fully-insured commercial business as well as higher earnings from our military services business resulting from higher performance incentives earned under the TRICARE contract.

Enrollment

- Fully-insured commercial group medical membership decreased 38,300 members, or 3.4% from December 31, 2016 reflecting lower membership in small group accounts due in part to more small group accounts selecting ASO products in 2017.
- Group ASO commercial medical membership decreased 114,500 members, or 20.0%, from December 31, 2016 to December 31, 2017 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment, partially offset by more small group accounts selecting ASO products in 2017.
- Specialty membership increased 24,800 members, or 0.4%, from December 31, 2016 to December 31, 2017 primarily due to strong growth in vision products marketed to employer groups.

Premiums revenue

- Group and Specialty segment premiums increased $76 million, or 1.1%, from 2016 to 2017 primarily due to an increase in group fully-insured commercial medical per-member premiums, partially offset by a decline in average group fully-insured commercial medical membership.

Services revenue

- Group and Specialty segment services revenue decreased $17 million, or 2.6%, from 2016 to 2017 primarily due to a decline in revenue in our group ASO commercial medical business mainly due to membership declines partially offset by higher revenue from our military services business resulting from higher performance incentives earned under the TRICARE contract.

Benefits expense

- The Group and Specialty segment benefit ratio increased 100 basis points from 78.2% in 2016 to 79.2% in 2017 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing of our products. The increase was further impacted by an increased proportion of small group members transitioning to community rated plans that carry a higher benefit ratio. These increases were partially offset by lower utilization for the fully-insured commercial medical business in 2017, primarily associated with the large group business.
- The Group and Specialty segment's benefits expense included the beneficial effect of $40 million in favorable prior-year medical claims reserve development in 2017 versus $46 million in 2016. This favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 60 basis points in 2017 versus approximately 70 basis points in 2016.

Operating costs

- The Group and Specialty segment operating cost ratio of 21.4% for 2017 decreased 210 basis points from 23.5% for 2016, primarily due to the temporary suspension of the health insurance industry fee for calendar year 2017 as well as operating cost efficiencies, partially offset by an increase in employee compensation costs resulting from the continued strong performance. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016.

Healthcare Services Segment

	2017	2016	Change	
			Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$ 181	$ 201	$ (20)	(10.0)%
Provider services	77	78	(1)	(1.3)%
Pharmacy solutions	80	31	49	158.1 %
Total services revenues	338	310	28	9.0 %
Intersegment revenues:				
Pharmacy solutions	20,881	21,952	(1,071)	(4.9)%
Provider services	1,593	1,677	(84)	(5.0)%
Clinical care services	1,111	1,343	(232)	(17.3)%
Total intersegment revenues	23,585	24,972	(1,387)	(5.6)%
Total services and intersegment revenues	$ 23,923	$ 25,282	$ (1,359)	(5.4)%
Income before income taxes	$ 967	$ 1,096	$ (129)	(11.8)%
Operating cost ratio	95.5%	95.2%		0.3 %

Segment Earnings

- Healthcare Services segment earnings of $967 million for 2017, a decrease of $129 million, or 11.8%, from 2016 primarily due to the impact of the optimization process associated with our chronic care management programs, as well as lower earnings in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. The reductions in pharmacy solutions intersegment revenues were offset by similar reductions in operating costs associated with the pharmacy solutions business.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 433 million in 2017, up 2% versus scripts of approximately 426 million in 2016. The increase primarily reflects growth associated with higher Medicare membership for 2017 than in 2016, partially offset by the decline in Individual Commercial membership.

Services revenue

- Services revenue increased $28 million, or 9.0%, from 2016 to $338 million for 2017 primarily due to service revenue growth from our pharmacy solutions business.

Intersegment revenues

- Intersegment revenues decreased $1.4 billion, or 5.6%, from 2016 to $23.6 billion for 2017 primarily due to care management programs discussed previously, as well as lower revenue in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. Our pharmacy solutions business revenues were impacted by improvements in net pharmacy costs driven by our pharmacy benefit manager and an increase in the generic dispensing rate. These items were partially offset by higher year-over-year script volume from growth in our Medicare Advantage and standalone PDP membership, partially offset by the impact of lower Individual Commercial membership. Our generic dispensing rate improved to 91.3% during 2017 from 90.5% during 2016. The higher generic dispensing rate

reduced revenues (and operating costs) for our pharmacy solutions business as generic drugs are generally priced lower than branded drugs.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.5% for 2017 was relatively unchanged from 95.2% for 2016.

Individual Commercial Segment

- As announced on February 14, 2017, we exited our Individual Commercial medical business January 1, 2018.
- In 2017, our Individual Commercial segment pretax income was $193 million, an increase of $1.1 billion, from a pretax loss of $869 million in 2016 primarily due to the exit of certain markets in 2017, and per-member premium increases, as well as the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program.
- Individual commercial medical membership decreased 526,000 members, or 80.3%, from December 31, 2016 to December 31, 2017 reflecting the decline in the number of counties we offered on-exchange coverage and the discontinuance of offering off-exchange products.
- The Individual Commercial segment benefit ratio of 57.4% for 2017 decreased from 107.7% in 2016 primarily due to the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program, as well as the planned exits in 2017 in certain markets that carried a higher benefit ratio and per-member premium increases.
- The Individual Commercial segment operating cost ratio of 21.2% for 2017 increased 160 basis points from 2016 primarily due to the loss of scale efficiency from market exits in 2017, partially offset by the write-off of receivables associated with the commercial risk corridor premium stabilization program and the temporary suspension of the health insurance industry fee for calendar year 2017.

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2018 Form 10-K.

Liquidity

Historically, our primary sources of cash have included receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities, borrowings, and proceeds from sales of businesses. Our primary uses of cash historically have included disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including premiums receivable, benefits payable, and other receivables and payables. Our cash flows are impacted by the timing of payments to and receipts from CMS associated with Medicare Part D subsidies for which we do not assume risk. The use of cash flows may be limited by regulatory requirements of state departments of insurance (or comparable state regulators) which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2018 Form 10-K.

Cash and cash equivalents decreased to $2.3 billion at December 31, 2018 from $4.0 billion at December 31, 2017. The change in cash and cash equivalents for the years ended December 31, 2018, 2017 and 2016 is summarized as follows:

	2018	2017	2016
		(in millions)	
Net cash provided by operating activities	$ 2,173	$ 4,051	$ 1,936
Net cash used in investing activities	(3,087)	(2,941)	(1,362)
Net cash (used in) provided by financing activities	(785)	(945)	732
(Decrease) increase in cash and cash equivalents	$ (1,699)	$ 165	$ 1,306

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The decrease in operating cash flows in 2018 primarily was due to the receipt of the merger termination fee in 2017, net of related expenses and taxes paid, funding the reinsurance of certain voluntary benefit and financial protection products to a third party in connection with the sale of KMG in 2018, and the timing of working capital items.

The increase in operating cash flows in 2017 primarily was due to the receipt of the merger termination fee, net of related expenses and taxes paid, higher earnings and the timing of working capital items.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. We illustrate these changes with the following summaries of benefits payable and receivables.

The detail of benefits payable was as follows at December 31, 2018, 2017 and 2016:

				Change		
	2018	2017	2016	2018	2017	2016
			(in millions)			
IBNR (1)	$ 3,361	$ 3,154	$ 3,422	$ 207	$ (268)	$ (308)
Reported claims in process (2)	617	614	654	3	(40)	54
Premium deficiency reserve (3)	—	—	—	—	—	(176)
Other benefits payable (4)	884	900	487	(16)	413	17
Total benefits payable	$ 4,862	$ 4,668	$ 4,563	194	105	(413)
Payables from disposition				58	—	—
Change in benefits payable per cash flow statement resulting in cash from operations				$ 252	$ 105	$ (413)

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).
(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.
(3) Premium deficiency reserve recognized for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.
(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increase in benefits payable in 2018 was primarily due to an increase in IBNR, mainly as a result of Medicare Advantage membership growth. The increase in benefits payable from 2016 to 2017 primarily was due to an increase in the amounts owed to providers under the capitated and risk sharing arrangements. This was partially offset by a decrease in IBNR primarily driven by declines in individual commercial medical membership in the 2017 period, partially offset by an increase in group Medicare Advantage membership. Benefits payable decreased in 2016 primarily due to a decrease in IBNR, as well as the application of 2016 results to the premium deficiency reserve liability recognized in 2015 associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year.

IBNR decreased during 2017 and 2016 primarily due to declines in individual and fully-insured group commercial membership. The decrease in IBNR during 2016 was also impacted by declines in group Medicare Advantage membership.

The detail of total net receivables was as follows at December 31, 2018, 2017 and 2016:

				Change		
	2018	2017	2016	2018	2017	2016
			(in millions)			
Medicare	$ 836	$ 511	$ 787	$ 325	$ (276)	$ 101
Commercial and other	135	273	579	(138)	(306)	39
Military services	123	166	32	(43)	134	(29)
Allowance for doubtful accounts	(79)	(96)	(118)	17	22	(3)
Total net receivables	$ 1,015	$ 854	$ 1,280	161	(426)	108
Reconciliation to cash flow statement:						
Provision for doubtful accounts				36	20	39
Change in receivables disposed from sale of business				3	—	11
Change in receivables per cash flow statement resulting in cash from operations				$ 200	$ (406)	$ 158

Medicare receivables are impacted by changes in revenue associated with individual and group Medicare membership changes as well as the timing of accruals and related collections associated with the CMS risk-adjustment model.

The decrease in commercial and other receivables in 2018 as compared to 2017, as well as the decrease in 2017 as compared to 2016, was due primarily to a decrease in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. This decrease corresponds with our exit from the Individual Commercial business.

Military services receivables at December 31, 2018, 2017, and 2016 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our TRICARE contracts. The 2017 balance also includes transition-in receivables under our T2017 East Region contract collected in 2018.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform law, also known as the 3R's, has impacted our operating cash flows over the last three years, but more significantly in 2017 and 2016 as the temporary risk corridor and reinsurance program provisions phased out in 2016. The timing of payments and receipts associated with these provisions impacted our operating cash flows as we built receivables for each coverage year that were expected to be collected in subsequent coverage years. Net collections under the 3Rs associated with prior coverage years were $8 million in 2018, $440 million in 2017 and $383 million in 2016. The annual health insurance industry fee was suspended for the calendar year 2017, but resumed in calendar year 2018. The annual health insurance industry fee was also suspended for the calendar year 2019 and, under current law, is scheduled to resume in calendar year 2020. We paid the federal government annual health insurance industry fees of $1.04 billion in 2018 and $916 million in 2016.

In addition to the timing of payments of benefits expense, receipts for premiums and services revenues, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other items impacting operating cash flows include income tax payments and the timing of payroll cycles.

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care

coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $612 million in 2018, $524 million in 2017, and $527 million in 2016.

In 2018, we completed the sale of our wholly-owned subsidiary KMG to CGIC. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. Total cash and cash equivalents, including parent company funding, disposed at the time of sale, was $805 million. See Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data

During 2018 we paid cash consideration of approximately $1.1 billion to acquire a 40% minority interest in Kindred at Home, $169 million to acquire the remaining interest in MCCI, and $185 million to acquire all of FPG, as discussed in Note 3 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $221 million, $2.4 billion, and $828 million during 2018, 2017 and 2016 respectively.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Claims payments were $653 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2018. Receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk were $1.9 billion higher than claims payments during 2017 and were $1.1 billion higher than claims payments during 2016. Our net payable for CMS subsidies and brand name prescription drug discounts was $331 million at December 31, 2018 compared to a net payable of $1.0 billion at December 31, 2017.

Under our administrative services only TRICARE contract, reimbursements from the federal government exceeded health care cost payments for which we do not assume risk by $38 million in 2018 and by $11 million in 2017. Health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $25 million in 2016.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $25 million in 2018. There were no reimbursements from HHS in 2018. Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $44 million in 2017 and by $28 million in 2016.

We repurchased common shares for $1.09 billion in 2018 and $3.37 billion in 2017 under share repurchase plans authorized by the Board of Directors and in connection with employee stock plans. We did not repurchase shares in 2016 due to restrictions under the Merger Agreement.

As discussed further below, we paid dividends to stockholders of $265 million in 2018, $220 million in 2017, and $177 million in 2016.

We entered into a commercial paper program in October 2014. Net proceeds from the issuance of commercial paper were $485 million in 2018 and the maximum principal amount outstanding at any one time during 2018 was $923 million. Net repayments of commercial paper were $153 million in 2017 and the maximum principal amount outstanding at any one time during 2017 was $500 million. Net repayments of commercial paper were $2 million in 2016 and the maximum principal amount outstanding at any one time during 2016 was $475 million.

In December 2017, we issued $400 million of 2.50% senior notes due December 15, 2020 and $400 million of 2.90% senior notes due December 15, 2022. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of December 31, 2017, were $794 million. We used the net proceeds, together with

available cash, to fund the redemption of our $300 million aggregate principal amount of 6.30% senior notes maturing in August 2018 and our $500 million aggregate principal amount of 7.20% senior notes maturing in June 2018 at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $829 million.

The remainder of the cash used in or provided by financing activities in 2018, 2017, and 2016 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

For a detailed discussion of dividends to stockholders, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Stock Repurchases

For a detailed discussion of stock repurchases, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Debt

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2018 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $250 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $1 million, up to a maximum 100 basis points, or annual interest expense by $3 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $578 million at December 31, 2018 from $688 million at December 31, 2017. This decrease primarily reflects acquisitions, common stock repurchases, insurance subsidiaries' capital contributions and capital expenditures, partially offset by insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated insurance subsidiaries paid dividends to the parent of $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. The amount of ordinary dividends that may be paid to our parent company in 2019 is approximately $1 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory

capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2018 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
	(in millions)				
Debt	$ 6,097	$ 1,697	$ 400	$ 1,000	$ 3,000
Interest (1)	8,955	1,926	1,161	914	4,954
Operating leases (2)	519	147	210	112	50
Purchase obligations (3)	736	240	337	159	—
Future policy benefits payable and other long-term liabilities (4)	724	53	444	68	159
Total	$ 17,031	$ 4,063	$ 2,552	$ 2,253	$ 8,163

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

Off-Balance Sheet Arrangements

As of December 31, 2018, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies primarily related to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2018	Percentage of Total	December 31, 2017	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,361	69.1%	$ 3,154	67.6%
Reported claims in process	617	12.7%	614	13.1%
Other benefits payable	884	18.2%	900	19.3%
Total benefits payable	$ 4,862	100.0%	$ 4,668	100.0%

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. For further discussion of our reserving methodology, including our use of completion and claims per member per month trend factors to estimate IBNR, refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2018 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.70%	$(258)	(3.00)%	$(224)
0.60%	$(222)	(2.75)%	$(206)
0.50%	$(185)	(2.50)%	$(187)
0.40%	$(148)	(2.25)%	$(168)
0.30%	$(111)	(2.00)%	$(150)
0.20%	$(74)	(1.75)%	$(131)
0.10%	$(37)	(1.50)%	$(112)

(a) Reflects estimated potential changes in benefits payable at December 31, 2018 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2018 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail, Group and Specialty, and Individual Commercial segment tables including information about incurred and paid claims development as of December 31, 2018, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 4,668	$ 4,563	$ 4,976
Less: Premium deficiency reserve	—	—	(176)
Less: Reinsurance recoverables	(70)	(76)	(85)
Balances at January 1, net	4,598	4,487	4,715
Incurred related to:			
Current year	46,385	44,001	45,318
Prior years	(503)	(483)	(582)
Total incurred	45,882	43,518	44,736
Paid related to:			
Current year	(41,736)	(39,496)	(40,852)
Prior years	(3,977)	(3,911)	(4,112)
Total paid	(45,713)	(43,407)	(44,964)
Reinsurance recoverable	95	70	76
Balances at December 31	$ 4,862	$ 4,668	$ 4,563

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2018		2017		2016	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (229)	(3.3)%	$ (279)	(2.7)%	$ (316)	(2.9)%
Completion factors	(274)	(0.8)%	(204)	(0.7)%	(266)	(0.9)%
Total	$ (503)		$ (483)		$ (582)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $503 million in 2018, $483 million in 2017, and $582 million in 2016. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2018, 2017, and 2016.

	Favorable Medical Claims Reserve Development			Change	
	2018	2017	2016	2018	2017
	(in millions)				
Retail Segment	$ (398)	$ (386)	$ (429)	$ (12)	$ 43
Group and Specialty Segment	(46)	(40)	(46)	(6)	6
Individual Commercial Segment	(57)	(56)	(106)	(1)	50
Other Businesses	(2)	(1)	(1)	(1)	—
Total	$ (503)	$ (483)	$ (582)	$ (20)	$ 99

The favorable medical claims reserve development for 2018, 2017, and 2016 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2018 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Premium deficiency reserve for short-duration policies	$ —	$ —	$ (176)
Military services	—	—	8
Future policy benefits	—	(22)	439
Total	$ —	$ (22)	$ 271

In 2016, we increased our existing premium deficiency reserve, initially recorded in 2015, for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies, which were sold in 2018, as more fully described below and in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and certain contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and recognized ratably during the year with adjustments each period to reflect changes in the ultimate premium.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the small group and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Medicare Advantage products are also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those

enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare," and in Item 1A. - Risk Factors.

Investment Securities

Investment securities totaled $10.4 billion, or 41% of total assets at December 31, 2018, and $12.3 billion, or 45% of total assets at December 31, 2017. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2018 and 2017. The fair value of debt securities were as follows at December 31, 2018 and 2017:

	12/31/2018	Percentage of Total	12/31/2017	Percentage of Total
			(dollars in millions)	
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 417	4.0%	$ 531	4.3%
Mortgage-backed securities	2,544	24.4%	1,610	13.1%
Tax-exempt municipal securities	2,771	26.5%	3,889	31.6%
Mortgage-backed securities:				
Residential	55	0.5%	26	0.2%
Commercial	523	5.0%	456	3.7%
Asset-backed securities	985	9.4%	408	3.3%
Corporate debt securities	3,142	30.2%	5,382	43.8%
Total debt securities	$ 10,437	100.0%	$ 12,302	100.0%

Approximately 97% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2018. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $118 million at December 31, 2018 and $222 million at December 31, 2017. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.4 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.3 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 9%.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2018:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2018						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 179	$ (1)	$ 153	$ (2)	$ 332	$ (3)
Mortgage-backed securities	956	(16)	1,019	(38)	1,975	(54)
Tax-exempt municipal securities	809	(9)	1,648	(28)	2,457	(37)
Mortgage-backed securities:						
Residential	—	—	15	—	15	—
Commercial	372	(8)	133	(6)	505	(14)
Asset-backed securities	824	(7)	40	—	864	(7)
Corporate debt securities	1,434	(35)	1,439	(63)	2,873	(98)
Total debt securities	$ 4,574	$ (76)	$ 4,447	$ (137)	$ 9,021	$ (213)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is other than temporary requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2018 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2018, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2018. There were no material other-than-temporary impairments in 2018, 2017, or 2016.

Goodwill and Long-lived Assets

At December 31, 2018, goodwill and other long-lived assets represented 23% of total assets and 58% of total stockholders' equity, compared to 19% and 52%, respectively, at December 31, 2017 with the increase due to our 2018 acquisitions.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our clinical and provider reporting units in our Healthcare Services segment. The margin on the clinical reporting unit would decline to less than 10% after factoring in a 100 basis point increase in the discount rate. The provider reporting unit, while not falling beneath this threshold, was closer than any of our other reporting units. The clinical and provider reporting units account for $524 million and $730 million, respectively, of goodwill.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. In the past we have, and in the future we may enter into interest rate swap agreements depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2018 or December 31, 2017.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2018. Our net unrealized position decreased $402 million from a net unrealized gain position of $198 million at December 31, 2017 to a net unrealized loss position of $204 million at December 31, 2018. At December 31, 2018, we had gross unrealized losses of $213 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2018. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 2.9 years as of December 31, 2018 and 4.1 years as of December 31, 2017. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $365 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2018 and 2017. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have not exceeded 300 basis points, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points twice, and have changed by less than 100 basis points eight times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2018						
Investment income (a)	$ (154)	$ (114)	$ (57)	$ 58	$ 116	$ 175
Interest expense (b)	31	20	10	(10)	(20)	(31)
Pretax	$ (123)	$ (94)	$ (47)	$ 48	$ 96	$ 144
As of December 31, 2017						
Investment income (a)	$ (87)	$ (83)	$ (67)	$ 67	$ 134	$ 202
Interest expense (b)	2	2	2	(2)	(3)	(5)
Pretax	$ (85)	$ (81)	$ (65)	$ 65	$ 131	$ 197

(a) As of December 31, 2018 and 2017, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2018 or December 31, 2017. There was $645 million and $150 million outstanding under our commercial paper program at December 31, 2018 and 2017, respectively. As of December 31, 2017, our interest rate under our commercial paper program was less than 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2018	2017
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,343	$ 4,042
Investment securities	10,026	9,557
Receivables, less allowance for doubtful accounts of $79 in 2018 and $96 in 2017	1,015	854
Other current assets	3,564	2,949
Total current assets	16,948	17,402
Property and equipment, net	1,735	1,584
Long-term investment securities	411	2,745
Equity method investment in Kindred at Home	1,047	—
Goodwill	3,897	3,281
Other long-term assets	1,375	2,166
Total assets	$ 25,413	$ 27,178
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,862	$ 4,668
Trade accounts payable and accrued expenses	3,067	4,069
Book overdraft	171	141
Unearned revenues	283	378
Short-term debt	1,694	150
Total current liabilities	10,077	9,406
Long-term debt	4,375	4,770
Future policy benefits payable	219	2,923
Other long-term liabilities	581	237
Total liabilities	15,252	17,336
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,594,841 shares issued at December 31, 2018 and 198,572,458 shares issued at December 31, 2017	33	33
Capital in excess of par value	2,535	2,445
Retained earnings	15,072	13,670
Accumulated other comprehensive (loss) income	(159)	19
Treasury stock, at cost, 63,028,169 shares at December 31, 2018 and 60,893,762 shares at December 31, 2017	(7,320)	(6,325)
Total stockholders' equity	10,161	9,842
Total liabilities and stockholders' equity	$ 25,413	$ 27,178

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions, except per share results)		
Revenues:			
Premiums	$ 54,941	$ 52,380	$ 53,021
Services	1,457	982	969
Investment income	514	405	389
Total revenues	56,912	53,767	54,379
Operating expenses:			
Benefits	45,882	43,496	45,007
Operating costs	7,525	6,567	7,173
Merger termination fee and related costs, net	—	(936)	104
Depreciation and amortization	405	378	354
Total operating expenses	53,812	49,505	52,638
Income from operations	3,100	4,262	1,741
Loss on sale of business	786	—	—
Interest expense	218	242	189
Other expense, net	33	—	—
Income before income taxes and equity in net earnings	2,063	4,020	1,552
Provision for income taxes	391	1,572	938
Equity in net earnings of Kindred at Home	11	—	—
Net income	$ 1,683	$ 2,448	$ 614
Basic earnings per common share	$ 12.24	$ 16.94	$ 4.11
Diluted earnings per common share	$ 12.16	$ 16.81	$ 4.07

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Net income	$ 1,683	$ 2,448	$ 614
Other comprehensive income (loss):			
Change in gross unrealized investment losses/gains	(189)	149	(101)
Effect of income taxes	51	(55)	38
Total change in unrealized investment gains/losses, net of tax	(138)	94	(63)
Reclassification adjustment for net realized gains included in investment income	(53)	(14)	(96)
Effect of income taxes	17	5	35
Total reclassification adjustment, net of tax	(36)	(9)	(61)
Other comprehensive (loss) income, net of tax	(174)	85	(124)
Comprehensive income attributable to our equity method investment in Kindred at Home	(4)	—	—
Comprehensive income	$ 1,505	$ 2,533	$ 490

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2016	198,372	$ 33	$ 2,530	$ 11,017	$ 58	$ (3,292)	$ 10,346
Net income				614			614
Other comprehensive loss					(124)		(124)
Common stock repurchases			—			(104)	(104)
Dividends and dividend equivalents			—	(177)			(177)
Stock-based compensation			115				115
Restricted stock unit vesting	13	—	(98)			98	—
Stock option exercises	110	—	13				13
Stock option and restricted stock tax benefit			2				2
Balances, December 31, 2016	198,495	33	2,562	11,454	(66)	(3,298)	10,685
Net income				2,448			2,448
Other comprehensive income					85		85
Common stock repurchases			(200)			(3,165)	(3,365)
Dividends and dividend equivalents			—	(232)			(232)
Stock-based compensation			157				157
Restricted stock unit vesting	—	—	(138)			138	—
Stock option exercises	77	—	64				64
Balances, December 31, 2017	198,572	33	2,445	13,670	19	(6,325)	9,842
Net income				1,683			1,683
Other comprehensive loss				(4)	(178)		(182)
Common stock repurchases			50			(1,140)	(1,090)
Dividends and dividend equivalents			—	(277)			(277)
Stock-based compensation			137				137
Restricted stock unit vesting	—	—	(145)			145	—
Stock option exercises	23	—	48				48
Balances, December 31, 2018	198,595	$ 33	$ 2,535	$ 15,072	$ (159)	$ (7,320)	$ 10,161

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Cash flows from operating activities			
Net income	$ 1,683	$ 2,448	$ 614
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss on sale of business	786	—	—
Net realized capital gains	(90)	(14)	(96)
Equity in net earnings of Kindred at Home	(11)	—	—
Stock-based compensation	137	157	115
Depreciation	444	410	388
Amortization	90	75	77
Provision (benefit) for deferred income taxes	194	132	(71)
Provision for doubtful accounts	36	20	39
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(200)	406	(158)
Other assets	(484)	(582)	426
Benefits payable	252	105	(413)
Other liabilities	(676)	641	937
Unearned revenues	(95)	98	(84)
Other	107	155	162
Net cash provided by operating activities	2,173	4,051	1,936
Cash flows from investing activities			
Acquisitions, net of cash acquired	(354)	(31)	(7)
Acquisition, equity method investment in Kindred at Home	(1,095)	—	—
Cash transferred in sale of business	(805)	—	—
Purchases of property and equipment	(612)	(524)	(527)
Purchases of investment securities	(4,687)	(6,265)	(6,566)
Maturities of investment securities	972	1,111	1,426
Proceeds from sales of investment securities	3,494	2,768	4,312
Net cash used in investing activities	(3,087)	(2,941)	(1,362)
Cash flows from financing activities			
(Withdrawals) receipts from contract deposits, net	(640)	1,823	1,093
Proceeds from issuance of senior notes, net	—	1,779	—
Proceeds from issuance (repayments) of commercial paper, net	485	(153)	(2)
Proceeds from term loan	1,000	—	—
Repayment of term loan	(350)	—	—
Repayment of long-term debt	—	(800)	—
Common stock repurchases	(1,090)	(3,365)	(104)
Dividends paid	(265)	(220)	(177)
Change in book overdraft	30	(71)	(89)
Proceeds from stock option exercises and other, net	45	62	11
Net cash (used in) provided by financing activities	(785)	(945)	732
(Decrease) increase in cash and cash equivalents	(1,699)	165	1,306
Cash and cash equivalents at beginning of year	4,042	3,877	2,571
Cash and cash equivalents at end of year	$ 2,343	$ 4,042	$ 3,877

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOW—(Continued)

	For the year ended December 31,		
	2018	2017	2016
Supplemental cash flow disclosures:		(in millions)	
Interest payments	$ 195	$ 216	$ 185
Income tax payments, net	$ 631	$ 1,498	$ 916
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 392	$ 31	$ 7
Less: Fair value of liabilities assumed	(38)	—	—
Cash paid for acquired businesses, net of cash acquired	$ 354	$ 31	$ 7

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 81% of our total premiums and services revenue from contracts with the federal government in 2018, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidate the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

Workforce Optimization

During the third quarter of 2017, we initiated a voluntary early retirement program and an involuntary workforce reduction program. These programs impacted approximately 3,600 associates, or 7.8% of our workforce. As a result, in 2017 we recorded charges of $148 million, or $0.64 per diluted common share. At December 31, 2017, $140 million was classified as a current liability, included in our consolidated balance sheet in the trade accounts payable and accrued expenses line. Payments under these programs are being made upon termination during the early retirement or severance pay period. The remaining workforce optimization liability at December 31, 2018, was $12 million and is expected to be paid in 2019.

Aetna Merger

On February 16, 2017, under the terms of the Agreement and Plan of Merger, or Merger Agreement, with Aetna Inc., and certain wholly owned subsidiaries of Aetna Inc., which we collectively refer to as Aetna, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned "Merger termination fee and related costs, net."

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges. Operating results for our individual commercial medical business compliant with the Health Care Reform Law were challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. As a result of these and other factors, we exited our individual commercial medical business effective January 1, 2018.

The annual premium-based fee on health insurers is not deductible for tax purposes. We estimate a liability for the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurance industry fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurance industry fee in September or October of each year. The Consolidated Appropriations Act enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurance industry fee. In 2018, we paid the federal government $1.04 billion for the annual health insurance industry fee attributed to calendar year 2018. In 2016, we paid the federal government $916 million for the annual health insurance industry fee attributed to calendar year 2016. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurance industry fee, but under current law, the fee is scheduled to resume in calendar year 2020.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets. Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of

credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and certain contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Premiums Revenue

We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium. Receivables or payables are classified as current or long-term in our consolidated balance sheet based on the timing of the expected settlement.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the small group and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Medicare Advantage products are also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent

funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2018, subsidy and discount payments of $10.3 billion exceeded reimbursements of $9.6 billion by $0.7 billion. For 2017, subsidy and discount reimbursements of $12.1 billion exceeded payments of $10.2 billion by $1.9 billion. For 2016, subsidy and discount reimbursements of $11.1 billion exceeded payments of $10.0 billion by $1.1 billion. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 7 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to customer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectibility of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

Under our TRICARE contracts with the Department of Defense (DoD) we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under our contracts net of estimated health care costs similar to an administrative services fee only agreement. Our contracts include fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2018, health care cost reimbursements and payments were each

approximately $5.6 billion, with reimbursements exceeding payments by $38 million for the year. For 2017, health care cost reimbursements and payments were each approximately $3.4 billion, with reimbursements exceeding payments by $11 million for the year. For 2016, health care cost reimbursements and payments were each approximately $3.3 billion with payments exceeding reimbursements by $25 million for the year.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

At December 31, 2018 and 2017, accounts receivable related to services were $123 million and $180 million, respectively. For the year ended December 31, 2018, we had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the consolidated balance sheet at December 31, 2018.

For the year ended December 31, 2018, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price), was not material. Further, revenue expected to be recognized in any future year related to remaining performance obligations was not material.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 7, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.3 billion at December 31, 2018 and $1.2 billion at December 31, 2017.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Life insurance, annuities, certain health and other supplemental, and, prior to the sale of our KMG subsidiary in 2018, long term care policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 5 years for computer software, and 10 to 20 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and definite-lived intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are

recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Equity Method Investments

We use the equity method of accounting for equity investments in companies where we are able to exercise significant influence, but not control, over operating and financial policies of the investee. Judgment regarding the level of influence over each equity method investment includes considering key factors such as our ownership interest, representation on the board of directors, organizational structure, participation in policy-making decisions and material intra-entity transactions.

Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by our share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies. Our proportionate share of the net income or loss of these companies is included in consolidated net income. Investment amounts in excess of our share of an investee's net assets are amortized over the life of the related asset creating the excess. Excess goodwill is not amortized.

We evaluate equity method investments for impairment whenever events or changes in circumstances indicate that the carrying amount of the investment might not be recoverable. Factors considered by us when reviewing an equity method investment for impairment include the length of time (duration) and the extent (severity) to which the fair value of the equity method investment has been less than carrying value, the investee's financial condition and near-term prospects and the intent and ability to hold the investment for a period of time sufficient to allow for anticipated recovery. An impairment that is other-than-temporary is recognized in the period identified.

See Note 4 for further information.

Goodwill and Definite-Lived Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting units that are expected to benefit from the specific synergies of the business combination.

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our clinical and provider reporting units in our Healthcare Services segment. The margin on the clinical reporting unit would decline to less than 10% after factoring in a 100 basis point increase in the discount rate. The provider reporting unit, while not falling beneath this threshold, was closer than any of our other reporting units. The clinical and provider reporting units account for $524 million and $730 million, respectively, of goodwill. Impairment tests completed for 2018, 2017, and 2016 did not result in an impairment loss.

Definite-lived intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Definite-lived intangible assets are amortized over the useful life generally using the straight-line method. We review definite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent two months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent two months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, and epidemics also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In 2016, we increased our existing $176 million premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year by $208 million. During 2016, the $384 million current period losses were applied to the premium deficiency liability for the 2016 coverage year.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including life insurance, annuities, certain health and other supplemental, and prior to its sale in 2018, long-term care policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on industry actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. During 2016, we recorded a loss for a premium deficiency as discussed further in Note 18.

We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. Health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the release of reserves for future policy benefits.

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Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model.

Additional detail regarding our stock-based compensation plans is included in Note 13.

Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares, or units, using the treasury stock method.

Additional detail regarding earnings per common share is included in Note 14.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than

exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment adviser. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board, or FASB, issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. Accordingly, our premiums revenue and investment income, collectively representing approximately 97% of our consolidated external revenues for the year ended December 31, 2018, are not included in the scope of the new guidance. We adopted the new standard effective January 1, 2018, using the modified retrospective approach. As the majority of our revenues are not subject to the new guidance and the remaining revenues' accounting treatment did not materially differ from pre-existing accounting treatment, the adoption of the new standard did not have a material impact on our consolidated results of operations, financial condition, cash flows, or related disclosures.

Accounting Pronouncements Effective in Future Periods

In February 2016, the FASB issued new guidance related to accounting for leases which requires lessees to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). We adopted the new standard effective January 1, 2019, as allowed, using the modified retrospective approach. We elected the package of practical expedients permitted under the transition guidance within the new standard, which among other things, allows us to carryforward the historical lease classification without restating comparative prior periods. We made a permitted accounting policy election to not apply the new guidance to leases with an initial term of 12 months or less. We will recognize those lease payments in the Consolidated Statements of Operations on a straight-line basis over the lease term. The adoption of the standard resulted in recognition of additional lease assets and lease liabilities of

approximately $470 million as of January 1, 2019. We believe the standard will not materially affect our consolidated net earnings, cash flows and liquidity.

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance is effective for us beginning January 1, 2020. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available for sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio consists of available for sale debt securities. We are currently evaluating the impact on our results of operations, financial condition, and cash flows.

In March 2017, the FASB issued new guidance that amends the accounting for premium amortization on purchased callable debt securities by shortening the amortization period. This amended guidance requires the premium to be amortized to the earliest call date instead of maturity date. The new guidance is effective for us beginning with annual and interim periods in 2019. This guidance will not have a material impact on our results of operations, financial condition or cash flows.

In February 2018, the FASB issued guidance which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the December 22, 2017 enactment of the Tax Cuts and Jobs Act. The new guidance is effective for us beginning January 1, 2019, with early adoption permitted. We early adopted this guidance in the first quarter of 2018 and it did not have a material impact on our results of operations, financial condition or cash flows.

In September 2018, the FASB issued new guidance related to accounting for long-duration contracts of insurers which revises key elements of the measurement models and disclosure requirements for long-duration contracts issued by insurers and reinsurers. The new guidance is effective for us beginning with annual and interim periods in 2021, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We are currently evaluating the impact on our results of operations, financial position and cash flows.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS AND DIVESTITURES

Acquisition of a 40% Minority Interest in Kindred's Homecare Business

On July 2, 2018, we completed the acquisition of a 40% minority interest in the Kindred at Home Division, or Kindred at Home, of Kindred Healthcare, Inc., or Kindred, for cash consideration of approximately $850 million. TPG Capital, or TPG, and Welsh, Carson, Anderson & Stowe, or WCAS, collectively, the Sponsors, along with us jointly created a consortium to purchase all of the outstanding and issued securities of Kindred. Immediately following the closing of that transaction, Kindred at Home and the Specialty Hospital company were separated, with the result being that the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital Company) are owned by the Sponsors and Kindred at Home is owned by a joint venture owned by the Sponsors and us.

On July 11, 2018, we, along with the same Kindred at Home Sponsors, TPG and WCAS completed the acquisition of privately-held Curo Health Services, or Curo, one of the nation's leading hospice operators providing care to patients at 245 locations in 22 states. The transaction was structured as a merger of Curo with the hospice business of Kindred at Home, and we thereby purchased a 40% minority interest in Curo for cash consideration of approximately $250 million.

We account for our 40% investment in Kindred at Home using the equity method of accounting. This investment is reflected as "Equity method investment in Kindred at Home" in our consolidated balance sheets, with our share of income or loss reported as "Equity in net earnings of Kindred at Home" in our consolidated statements of income.

We entered into a shareholders agreement with the Sponsors that provides for certain rights and obligations of each party. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture starting at the end of year three and ending at the end of year four following the closing. Likewise, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning at the end of 2022 and ending at the end of 2023 following the closing. The put and call options, which are exercisable at a fixed EBITDA multiple and provide a minimum return on the Sponsor's investment if exercised, are measured at fair value each period using a Monte Carlo simulation. The simulation relies on assumptions around Kindred at Home's equity value, risk free interest rates, volatility, and the details specific to the put and call options. The final purchase price allocation resulted in approximately $1 billion being allocated to the investment and $236 million and $291 million allocated to the put and call options, respectively. The fair values of the put option and call option were $224 million and $246 million, respectively, at December 31, 2018. The put option is included within other long-term liabilities and the call option is included within other long-term assets. The change in fair value of the put and call options is reflected as "Other expense, net" in our consolidated statements of income.

Sale of Closed Block of Commercial Long-Term Care Insurance Business

On August 9, 2018, we completed the sale of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care policies. Upon closing, we funded the transaction with approximately $190 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $160 million of statutory capital with the sale. In connection with the sale of KMG, we recognized a pretax loss, including transaction costs, of $786 million and a corresponding $452 million tax benefit.

Prior to the sale of KMG, we entered into reinsurance contracts to transfer the risk associated with certain voluntary benefit and financial protection products previously issued primarily by KIC to a third party. We transferred approximately $245 million of cash to the third party and recorded a commensurate reinsurance recoverable as a result of these transactions. The reinsurance recoverable was included as part of the net assets disposed. There was no material impact to operating results from these reinsurance transactions.

KMG revenues and net income for the 2018 period prior to the date of sale was $182 million and $47 million, respectively. KMG revenues and net loss were $261 million and $117 million, respectively, for the year ended December 31, 2017 and $249 million and $336 million, respectively, for the year ended December 31, 2016.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The assets and liabilities of KMG that were disposed of on August 9, 2018 were as follows:

	August 9, 2018 (in millions)
Assets	
Cash and cash equivalents	$ 805
Receivables, net	3
Investment securities	1,576
Other assets	1,085
Total assets disposed	$ 3,469
Liabilities	
Benefits payable	$ 58
Trade accounts payable and accrued expenses	70
Future policy benefits payable	2,573
Total liabilities disposed	$ 2,701

Other Acquisitions and Divestitures

On March 1, 2018, we acquired the remaining equity interest in MCCI Holdings, LLC, or MCCI, a privately held management service organization and healthcare provider headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. The purchase price consisted primarily of $169 million cash, as well as our existing investment in MCCI and a note receivable and a revolving note with an aggregate balance of $383 million. This resulted in a preliminary purchase price allocation to goodwill of $483 million, definite-lived intangible assets of $80 million, and net tangible assets of $24 million. The goodwill was assigned to the Retail and Healthcare Services segments. The definite-lived intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 8 years.

On April 10, 2018, we acquired Family Physicians Group, or FPG, for cash consideration of approximately $185 million, net of cash received. FPG serves Medicare Advantage and Managed Medicaid HMO patients in Greater Orlando, Florida with a footprint that includes clinics located in Lake, Orange, Osceola and Seminole counties. This resulted in a preliminary purchase price allocation to goodwill of $133 million, definite-lived intangible assets of $38 million and net tangible assets of $14 million. The goodwill was assigned to the Retail and Healthcare Services segments. The other intangible assets, which primarily consist of customer contracts, have an estimated weighted average useful life of 5 years.

The purchase price allocations for MCCI and FPG are preliminary, subject to receipt and validation of certain tax related analyses.

During 2017 and 2016, we acquired certain other health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates.

Acquisition-related costs recognized in each of 2018, 2017 and 2016 were not material to our results of operations. Goodwill and definite-lived intangible assets acquired are partially amortizable as deductible expenses for tax purposes. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

4. EQUITY METHOD INVESTMENT

The summarized balance sheet at December 31, 2018 and income statement for the period beginning July 2, 2018 through December 31, 2018 of Kindred at Home in which we hold a 40% equity interest was as follows:

Balance sheet	**December 31, 2018**
	(in millions)
Current assets	$ 536
Non-current assets	4,955
Current liabilities	351
Non-current liabilities	2,708
Shareholders' equity	2,432

Statement of income	**July 2, 2018 through December 31, 2018**
	(in millions)
Revenues	$ 1,587
Expenses	1,451
Net income	27

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

5. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2018 and 2017, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2018				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 419	$ 1	$ (3)	$ 417
Mortgage-backed securities	2,595	3	(54)	2,544
Tax-exempt municipal securities	2,805	3	(37)	2,771
Mortgage-backed securities:				
Residential	55	—	—	55
Commercial	537	—	(14)	523
Asset-backed securities	991	1	(7)	985
Corporate debt securities	3,239	1	(98)	3,142
Total debt securities	$ 10,641	$ 9	$ (213)	$ 10,437
December 31, 2017				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 532	$ 1	$ (2)	$ 531
Mortgage-backed securities	1,625	4	(19)	1,610
Tax-exempt municipal securities	3,884	33	(28)	3,889
Mortgage-backed securities:				
Residential	26	—	—	26
Commercial	455	3	(2)	456
Asset-backed securities	407	1	—	408
Corporate debt securities	5,175	244	(37)	5,382
Total debt securities	$ 12,104	$ 286	$ (88)	$ 12,302

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2018 and 2017, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2018						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 179	$ (1)	$ 153	$ (2)	$ 332	$ (3)
Mortgage-backed securities	956	(16)	1,019	(38)	1,975	(54)
Tax-exempt municipal securities	809	(9)	1,648	(28)	2,457	(37)
Mortgage-backed securities:						
Residential	—	—	15	—	15	—
Commercial	372	(8)	133	(6)	505	(14)
Asset-backed securities	824	(7)	40	—	864	(7)
Corporate debt securities	1,434	(35)	1,439	(63)	2,873	(98)
Total debt securities	$ 4,574	$ (76)	$ 4,447	$ (137)	$ 9,021	$ (213)
December 31, 2017						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 273	$ (1)	$ 130	$ (1)	$ 403	$ (2)
Mortgage-backed securities	581	(2)	672	(17)	1,253	(19)
Tax-exempt municipal securities	1,590	(16)	661	(12)	2,251	(28)
Mortgage-backed securities:						
Residential	20	—	3	—	23	—
Commercial	131	(1)	28	(1)	159	(2)
Asset-backed securities	107	—	10	—	117	—
Corporate debt securities	1,297	(10)	804	(27)	2,101	(37)
Total debt securities	$ 3,999	$ (30)	$ 2,308	$ (58)	$ 6,307	$ (88)

Approximately 97% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2018. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Tax-exempt municipal securities were diversified among general obligation bonds of states and local municipalities in the United States as well as special revenue bonds issued by municipalities to finance specific public works projects such as utilities, water and sewer, transportation, or education. Our general obligation bonds are diversified across the United States with no individual state exceeding 9%. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Our unrealized loss from all securities was generated from approximately 1,210 positions out of a total of approximately 1,500 positions at December 31, 2018. All issuers of securities we own that were trading at an unrealized loss at December 31, 2018 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the securities were purchased. At December 31, 2018, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we

will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2018.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2018, 2017, and 2016:

	2018	2017	2016
	(in millions)		
Gross realized gains	$ 106	$ 35	$ 120
Gross realized losses	(16)	(21)	(24)
Net realized capital gains	$ 90	$ 14	$ 96

There were no material other-than-temporary impairments in 2018, 2017, or 2016.

The contractual maturities of debt securities available for sale at December 31, 2018, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 943	$ 941
Due after one year through five years	2,929	2,873
Due after five years through ten years	1,873	1,810
Due after ten years	718	706
Mortgage and asset-backed securities	4,178	4,107
Total debt securities	$ 10,641	$ 10,437

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

6. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2018 and 2017, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2018				
Cash equivalents	$ 2,024	$ 2,024	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	417	—	417	—
Mortgage-backed securities	2,544	—	2,544	—
Tax-exempt municipal securities	2,771	—	2,771	—
Mortgage-backed securities:				
Residential	55	—	55	—
Commercial	523	—	523	—
Asset-backed securities	985	—	985	—
Corporate debt securities	3,142	—	3,142	—
Total debt securities	10,437	—	10,437	—
Total invested assets	$ 12,461	$ 2,024	$ 10,437	$ —
December 31, 2017				
Cash equivalents	$ 4,564	$ 4,564	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	531	—	531	—
Mortgage-backed securities	1,610	—	1,610	—
Tax-exempt municipal securities	3,889	—	3,889	—
Mortgage-backed securities:				
Residential	26	—	26	—
Commercial	456	—	456	—
Asset-backed securities	408	—	408	—
Corporate debt securities	5,382	—	5,381	1
Total debt securities	12,302	—	12,301	1
Total invested assets	$ 16,866	$ 4,564	$ 12,301	$ 1

The table above does not include the fair value of the put and call options associated with our equity investment in Kindred at Home. See Note 3 for further information.

Financial Liabilities

Our debt is recorded at carrying value in our consolidated balance sheets. The carrying value of our senior notes debt outstanding, net of unamortized debt issuance costs, was $4,774 million at December 31, 2018 and $4,770 million at December 31, 2017. The fair value of our senior note debt was $4,885 million at December 31, 2018 and $5,191 million at December 31, 2017. The fair value of our senior note debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities. Due to the short-term nature, carrying value approximates fair value for our term note and commercial paper borrowings. The term loan outstanding and commercial paper borrowings were $1,295 million at December 31, 2018, compared to $150 million at December 31, 2017.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we acquired MCCI, FPG, and other health and wellness related businesses during 2018, 2017, and 2016. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected future cash flows and discount rates used in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2018, 2017, or 2016.

7. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2018 and 2017. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2018		2017	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 15	$ 172	$ 4	$ 101
Trade accounts payable and accrued expenses	(103)	(503)	(255)	(1,085)
Net current liability	(88)	(331)	(251)	$ (984)
Other long-term assets	7	—	—	—
Other long-term liabilities	(89)	—	(28)	—
Net long-term liability	(82)	—	(28)	—
Total net liability	$ (170)	$ (331)	$ (279)	$ (984)

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2018 and 2017.

	2018	2017
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	766	713
Equipment	890	824
Computer software	2,372	2,003
	4,048	3,560
Accumulated depreciation	(2,313)	(1,976)
Property and equipment, net	$ 1,735	$ 1,584

Depreciation expense was $444 million in 2018, $410 million in 2017, and $388 million in 2016, including amortization expense for capitalized internally developed and purchased software of $298 million in 2018, $287 million in 2017, and $255 million in 2016.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2018 and 2017 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2017	$ 1,059	$ 261	$ 1,952	$ 3,272
Acquisitions	—	—	9	9
Balance at December 31, 2017	1,059	261	1,961	3,281
Acquisitions	476	—	140	616
Balance at December 31, 2018	$ 1,535	$ 261	$ 2,101	$ 3,897

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2018 and 2017.

	Weighted Average Life	2018			2017		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
		(in millions)					
Other intangible assets:							
Customer contracts/relationships	8.7 years	$ 646	$ 434	$ 212	$ 566	$ 401	$ 165
Trade names and technology	6.4 years	84	83	1	104	84	20
Provider contracts	11.8 years	68	37	31	68	30	38
Noncompetes and other	7.3 years	29	28	1	32	29	3
Total other intangible assets	8.7 years	$ 827	$ 582	$ 245	$ 770	$ 544	$ 226

Amortization expense for other intangible assets was approximately $90 million in 2018, $75 million in 2017, and $77 million in 2016. Amortization expense for 2018 included $12 million associated with the write-off of a trade name value reflecting the re-branding of certain provider assets.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2019	$ 70
2020	67
2021	34
2022	31
2023	18

10. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 4,668	$ 4,563	$ 4,976
Less: Premium deficiency reserve	—	—	(176)
Less: Reinsurance recoverables	(70)	(76)	(85)
Balances at January 1, net	4,598	4,487	4,715
Incurred related to:			
Current year	46,385	44,001	45,318
Prior years	(503)	(483)	(582)
Total incurred	45,882	43,518	44,736
Paid related to:			
Current year	(41,736)	(39,496)	(40,852)
Prior years	(3,977)	(3,911)	(4,112)
Total paid	(45,713)	(43,407)	(44,964)
Reinsurance recoverable	95	70	76
Balances at December 31	$ 4,862	$ 4,668	$ 4,563

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $503 million in 2018, $483 million in 2017, and $582 million in 2016. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2018, 2017, and 2016.

	Favorable Medical Claims Reserve Development		
	2018	2017	2016
Retail Segment	$ (398)	$ (386)	$ (429)
Group and Specialty Segment	(46)	(40)	(46)
Individual Commercial Segment	(57)	(56)	(106)
Other Businesses	(2)	(1)	(1)
Total	$ (503)	$ (483)	$ (582)

The favorable medical claims reserve development for 2018, 2017, and 2016 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development primarily resulted from our Medicare Advantage and individual commercial medical businesses.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Premium deficiency reserve for short-duration policies	$ —	$ —	$ (176)
Military services	—	—	8
Future policy benefits	—	(22)	439
Total	$ —	$ (22)	$ 271

Military services benefits expense for 2016 in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies, which were sold in 2018, as more fully described in Note 18.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2018, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2016 and 2017 is presented as supplementary information.

Claims frequency is measured as medical fee-for-service claims for each service encounter with a unique provider identification number. Our claims frequency measure includes claims covered by deductibles as well as claims under capitated arrangements. Claim counts may vary based on product mix and the percentage of delegated capitation arrangements.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 3,963	$ 3,506	$ 3,600
Less: Reinsurance recoverables	(70)	(76)	(85)
Balances at January 1, net	3,893	3,430	3,515
Incurred related to:			
Current year	41,323	38,604	37,212
Prior years	(398)	(386)	(429)
Total incurred	40,925	38,218	36,783
Paid related to:			
Current year	(37,189)	(34,781)	(33,784)
Prior years	(3,386)	(2,974)	(3,084)
Total paid	(40,575)	(37,755)	(36,868)
Reinsurance recoverable	95	70	76
Balances at December 31	$ 4,338	$ 3,963	$ 3,506

At December 31, 2018, benefits payable for our Retail segment included IBNR of approximately $2.9 billion, primarily associated with claims incurred in 2018. The cumulative number of reported claims as of December 31, 2018 was approximately 104.3 million for claims incurred in 2018, 102.1 million for claims incurred in 2017, and 96.2 million for claims incurred in 2016.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2018, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2016 Unaudited	2017 Unaudited	2018
		(in millions)	
2016	$ 37,212	$ 36,891	$ 36,811
2017		38,604	38,341
2018			41,323
Total			$ 116,475

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2016 Unaudited	2017 Unaudited	2018
	(in millions)		
2016	$ 33,784	$ 36,841	$ 36,811
2017		34,781	38,232
2018			37,189
Total			$ 112,232
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 4,243

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
	(in millions)		
Balances at January 1	$ 568	$ 579	$ 616
Less: Reinsurance recoverables	—	—	—
Balances at January 1, net	568	579	616
Incurred related to:			
Current year	5,466	5,403	5,271
Prior years	(46)	(40)	(46)
Total incurred	5,420	5,363	5,225
Paid related to:			
Current year	(4,957)	(4,843)	(4,700)
Prior years	(514)	(531)	(562)
Total paid	(5,471)	(5,374)	(5,262)
Balances at December 31	$ 517	$ 568	$ 579

At December 31, 2018, benefits payable for our Group and Specialty segment included IBNR of approximately $448 million, primarily associated with claims incurred in 2018. The cumulative number of reported claims as of December 31, 2018 was approximately 10.4 million for claims incurred in 2018, 11.1 million for claims incurred in 2017, and 12.9 million for claims incurred in 2016.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2018, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2016 Unaudited	2017 Unaudited	2018
	(in millions)		
2016	$ 5,271	$ 5,234	$ 5,235
2017		5,403	5,358
2018			5,466
Total			$ 16,059

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2016 Unaudited	2017 Unaudited	2018
	(in millions)		
2016	$ 4,700	$ 5,226	$ 5,234
2017		4,843	5,351
2018			4,957
Total			$ 15,542
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 517

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Individual Commercial Segment

Activity in benefits payable for our Individual Commercial segment, was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Balances at January 1	$ 101	$ 454	$ 741
Less: Premium deficiency reserve	—	—	(176)
Balances at January 1, net	101	454	565
Incurred related to:			
Current year	—	669	3,677
Prior years	(56)	(56)	(106)
Total incurred	(56)	613	3,571
Paid related to:			
Current year	—	(583)	(3,233)
Prior years	(38)	(383)	(449)
Total paid	(38)	(966)	(3,682)
Balances at December 31	$ 7	$ 101	$ 454

At December 31, 2018, benefits payable for our Individual Commercial segment included IBNR of approximately $1 million, associated with claims prior to 2018. The cumulative number of reported claims as of December 31, 2017 was approximately 2.2 million for claims incurred in 2017 and 9.5 million for claims incurred in 2016.

The following tables provide information about incurred and paid claims development for the Individual Commercial segment as of December 31, 2018, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2016 Unaudited	2017 Unaudited	2018
		(in millions)	
2016	$ 3,677	$ 3,621	$ 3,609
2017		669	627
2018			—
Total			$ 4,236

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2016 Unaudited	2017 Unaudited	2018
		(in millions)	
2016	$ 3,233	$ 3,606	$ 3,609
2017		583	620
2018			—
Total			$ 4,229
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 7

Reconciliation to Consolidated

The reconciliation of the net incurred and paid claims development tables to benefits payable in the consolidated statement of financial position is as follows:

	December 31, 2018
Net outstanding liabilities	
Retail	$ 4,243
Group and Specialty	517
Individual Commercial	7
Benefits payable, net of reinsurance	4,767
Reinsurance recoverable on unpaid claims	
Retail	95
Total benefits payable, gross	$ 4,862

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Current provision:			
Federal	$ 139	$ 1,324	$ 921
States and Puerto Rico	58	116	88
Total current provision	197	1,440	1,009
Deferred expense (benefit)	194	132	(71)
Provision for income taxes	$ 391	$ 1,572	$ 938

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2018, 2017 and 2016 due to the following:

	2018	2017	2016
		(in millions)	
Income tax provision at federal statutory rate	$ 436	$ 1,407	$ 543
States, net of federal benefit, and Puerto Rico	42	80	41
Tax exempt investment income	(11)	(22)	(20)
Health insurance industry fee	243	—	336
Nondeductible executive compensation	17	36	30
Tax reform	(39)	133	—
KMG sale	(272)	—	—
Other, net	(25)	(62)	8
Provision for income taxes	$ 391	$ 1,572	$ 938

The tax reform law enacted on December 22, 2017 (the "Tax Reform Law") reduced the statutory federal corporate income tax rate to 21 percent from 35 percent, beginning in 2018, and required a mandatory deemed repatriation of undistributed foreign earnings. The rate reduction required a remeasurement of our net deferred tax asset. These items resulted in an estimated increase in our 2017 tax provision of approximately $133 million, including approximately $10 million for the deemed repatriation tax imposed on the undistributed earnings of our Puerto Rico operations. Revisions to our prior estimate for the income tax effects of the Tax Reform Law decreased our 2018 tax provision by approximately $39 million.

The incremental tax benefit on the sale of KMG of $272 million resulted from a tax loss higher than the loss recorded in the statement of income for the year ended December 31, 2018 due to a higher tax basis in KMG than book basis. In addition, the amount reflects our ability to carryback the capital loss to tax years 2015, 2016 and 2017 at the historical tax rate of 35 percent instead of the current tax rate of 21 percent.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Principal components of our net deferred tax balances at December 31, 2018 and 2017 were as follows:

	Assets (Liabilities)	
	2018	2017
	(in millions)	
Compensation and other accrued expense	$ 89	$ 138
Benefits payable	79	113
Investment securities	44	—
Net operating loss carryforward	38	53
Capital loss carryforward	15	—
Deferred acquisition costs	17	48
Unearned revenues	9	12
Other	8	1
Future policy benefits payable	—	231
Total deferred income tax assets	299	596
Valuation allowance	(54)	(49)
Total deferred income tax assets, net of valuation allowance	245	547
Depreciable property and intangible assets	(273)	(237)
Prepaid expenses	(52)	(44)
Future policy benefits payable	(5)	—
Investment securities	—	(49)
Total deferred income tax liabilities	(330)	(330)
Total net deferred income tax assets/(liabilities)	$ (85)	$ 217

All deferred tax liabilities and assets are classified as noncurrent in our consolidated balance sheets as other long-term liabilities at December 31, 2018 and as other long-term assets at December 31, 2017.

At December 31, 2018, we had approximately $104 million of net operating losses and $64 million of capital losses to carry forward. These loss carryforwards, if not used to offset future taxable income or capital gain, will expire from 2019 through 2037. Due to limitations and uncertainty regarding our ability to use some of the loss carryforwards and certain other deferred tax assets, a valuation allowance of $54 million was established. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover these deferred tax assets.

We file income tax returns in the United States and Puerto Rico. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2016 and prior years. Our 2017 tax return is in the post-filing review period under the Compliance Assurance Process, or CAP. Our 2018 tax return is under advance review by the IRS under CAP. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2015. We are not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

12. DEBT

The carrying value of debt outstanding was as follows at December 31, 2018 and 2017:

	2018	2017
	(in millions)	
Short-term debt:		
Commercial paper	$ 645	150
Term note	650	—
Senior note:		
$400 million, 2.625% due October 1, 2019	399	—
Total short-term debt	$ 1,694	$ 150
Long-term debt:		
Senior notes:		
$400 million, 2.625% due October 1, 2019	$ —	$ 399
$400 million, 2.50% due December 15, 2020	398	397
$400 million, 2.90% due December 15, 2022	396	396
$600 million, 3.15% due December 1, 2022	596	595
$600 million, 3.85% due October 1, 2024	597	595
$600 million, 3.95% due March 15, 2027	594	594
$250 million, 8.15% due June 15, 2038	263	263
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	739
$400 million, 4.80% due March 15, 2047	396	396
Total long-term debt	$ 4,375	$ 4,770

Maturities of the short-term and long-term debt for the years ending December 31, are as follows:

For the years ending December 31,	(in millions)
2019	$ 1,697
2020	400
2021	—
2022	1,000
2023	—
Thereafter	3,000

Senior Notes

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes contain a change of control provision that may require us to purchase the notes under certain circumstances. We recognized a loss on extinguishment of debt of approximately $17 million in 2017 for the early redemption of senior notes, which is included in interest expense in the consolidated statements of income.

Credit Agreement

Our 5-year, $2.0 billion unsecured revolving credit agreement expires May 2022. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110.0 basis points, varies depending on our credit ratings ranging from 91.0 to 150.0 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15.0 basis points, may fluctuate between 9.0 and 25.0 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive covenants and a financial covenant regarding maximum debt to capitalization of 50% as well as customary events of default. We are in compliance with this financial covenant, with an actual debt to capitalization of 37% as measured in accordance with the credit agreement as of December 31, 2018. Upon our agreement with one or more financial institutions, we may expand the aggregate commitments under the credit agreement to a maximum of $2.5 billion, through a $500 million incremental loan facility.

At December 31, 2018, we had no borrowings and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2018, we had $2 billion of remaining borrowing capacity (which excludes the uncommitted $500 million incremental loan facility under the credit agreement), none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

Under our commercial paper program we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers at any time not to exceed $2 billion. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2018 was $923 million, with $645 million outstanding at December 31, 2018 compared to $150 million outstanding at December 31, 2017. The outstanding commercial paper at December 31, 2018 had a weighted average annual interest rate of 3.06%.

Term Note

In November 2018, we entered into a $1.0 billion term note agreement with a bank at a variable rate of interest due within one year. We may elect to incur interest at either the bank's base rate or LIBOR plus 115 basis points. The base rate is defined as the higher of the daily federal funds rate plus 50 basis points; or the bank's prime rate; or LIBOR plus 100 basis points. The interest rate in effect at December 31, 2018 was 3.67%. The note is prepayable without penalty. Proceeds were primarily used to fund the November 2018 accelerated stock repurchase agreement. We repaid $350 million prior to December 31, 2018. The term note shares the customary terms and provisions as well as financial covenants of our Credit Agreement, as discussed above.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $197 million in 2018, $217 million in 2017, and $196 million in 2016. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $286.48 on December 31, 2018, approximately 12% of the retirement and savings plan's assets were invested in our common stock, or approximately 1.8 million shares, representing approximately 1.3% of the shares outstanding as of

December 31, 2018. At December 31, 2018, approximately 2.0 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. Awards generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2018, 2017, and 2016:

	2018	2017	2016
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 124	$ 145	$ 106
Stock options	13	12	9
Total stock-based compensation expense	137	157	115
Tax benefit recognized	(21)	(32)	(20)
Stock-based compensation expense, net of tax	$ 116	$ 125	$ 95

Stock-based compensation expense for certain restricted stock in 2017 included a $29 million modification expense for certain awards.

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $49 million in 2018, $68 million in 2017, and $53 million in 2016. There was no capitalized stock-based compensation expense during these years.

At December 31, 2018, there were 13.1 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 4.7 million shares of common stock available for future grants assuming all stock options were granted or 2.0 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

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Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock grants also include performance-based conditions generally associated with return on invested capital and strategic membership growth. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $276.62 in 2018, $222.35 in 2017, and $168.12 in 2016. Activity for our restricted stock was as follows for the year ended December 31, 2018:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2017	1,653	$ 171.68
Granted	576	276.62
Vested	(1,045)	185.82
Forfeited	(220)	180.83
Nonvested restricted stock at December 31, 2018	964	$ 213.99

Approximately 12% of the nonvested restricted stock at December 31, 2018 included performance-based conditions.

The fair value of shares vested was $298 million during 2018, $306 million during 2017, and $253 million during 2016. Total compensation expense not yet recognized related to nonvested restricted stock was $156 million at December 31, 2018. We expect to recognize this compensation expense over a weighted-average period of approximately 1.8 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2018, 2017, and 2016 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2018	2017	2016
Weighted-average fair value at grant date	$ 63.67	$ 49.81	$ 37.12
Expected option life (years)	4.1 years	4.1 years	4.2 years
Expected volatility	26.1%	27.1%	27.6%
Risk-free interest rate at grant date	2.5%	2.0%	1.1%
Dividend yield	0.7%	0.7%	0.7%

When valuing employee stock options, we stratify the employee population into three homogeneous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2018:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2017	863	$ 181.44
Granted	143	276.01
Exercised	(320)	157.44
Forfeited	(9)	150.59
Options outstanding at December 31, 2018	677	$ 213.17
Options exercisable at December 31, 2018	178	$ 180.76

As of December 31, 2018, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $48 million, and a weighted-average remaining contractual term of 5 years. As of December 31, 2018, exercisable stock options had an aggregate intrinsic value of $19 million, and a weighted-average remaining contractual term of 4.1 years. The total intrinsic value of stock options exercised during 2018 was $43 million, compared with $44 million during 2017 and $18 million during 2016. Cash received from stock option exercises totaled $50 million in 2018, $63 million in 2017, and $14 million in 2016.

Total compensation expense not yet recognized related to nonvested options was $14 million at December 31, 2018. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 1,683	$ 2,448	$ 614
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	137,486	144,493	149,375
Dilutive effect of:			
Employee stock options	194	172	219
Restricted stock	723	920	1,323
Shares used to compute diluted earnings per common share	138,403	145,585	150,917
Basic earnings per common share	$ 12.24	$ 16.94	$ 4.11
Diluted earnings per common share	$ 12.16	$ 16.81	$ 4.07
Number of antidilutive stock options and restricted stock awards excluded from computation	223	539	748

Humana Inc.
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15. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2016, 2017, and 2018 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2016	$1.16	$172
2017	$1.49	$216
2018	$1.90	$262

On November 2, 2018, the Board declared a cash dividend of $0.50 per share that was paid on January 25, 2019 to stockholders of record on December 31, 2018, for an aggregate amount of $68 million. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

In February 2019, the Board declared a cash dividend of $0.55 per share payable on April 26, 2019 to stockholders of record on March 29, 2019.

Stock Repurchases

Our Board of Directors may authorize the purchase of our common shares. Under our share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing.

On February 14, 2017, our Board of Directors authorized the repurchase of up to $2.25 billion of our common shares expiring on December 31, 2017, exclusive of shares repurchased in connection with employee stock plans.

On February 16, 2017, we entered into an accelerated share repurchase agreement, the February 2017 ASR, with Goldman, Sachs & Co. LLC, or Goldman Sachs, to repurchase $1.5 billion of our common stock as part of the $2.25 billion share repurchase authorized on February 14, 2017. On February 22, 2017, we made a payment of $1.5 billion to Goldman Sachs from available cash on hand and received an initial delivery of 5.83 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $1.2 billion increase in treasury stock, which reflected the value of the initial 5.83 million shares received upon initial settlement, and a $300 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the February 2017 ASR. Upon settlement of the February 2017 ASR on August 28, 2017, we received an additional 0.84 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the agreement of $224.81, less a discount and subject to adjustments pursuant to the terms and conditions of the February 2017 ASR, bringing the total shares received under this program to 6.67 million. In addition, upon settlement we reclassified the $300 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock. Subsequent to settlement of the February 2017 ASR, we repurchased an additional 3.04 million shares in the open market, utilizing the remaining $750 million of the $2.25 billion authorization prior to expiration.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans.

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On December 21, 2017, we entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflected the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Upon settlement of the ASR on March 26, 2018, we received an additional 0.46 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement of $267.55, bringing the total shares received under this program to 3.74 million. In addition, upon settlement we reclassified the $200 million value of stock initially held back by BofA from capital in excess of par value to treasury stock.

On November 28, 2018, we entered into an accelerated stock repurchase agreement, the November 2018 ASR, with Goldman Sachs to repurchase $750 million of our common stock as part of the $3.0 billion share repurchase program authorized by the Board of Directors on December 14, 2017. On November 29, 2018, we made a payment of $750 million to Goldman Sachs from available cash on hand and received an initial delivery of 1.94 million shares of our common stock from Goldman Sachs. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $600 million increase in treasury stock, which reflects the value of the initial 1.94 million shares received upon initial settlement, and a $150 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the November 2018 ASR. The final number of shares that we may receive, or be required to remit, under the agreement will be determined based on the daily volume-weighted average share price of our common stock over the term of the agreement, less a discount and subject to adjustments pursuant to the terms and conditions of the agreement. Final settlement under the November 2018 ASR is expected to occur by the end of the first quarter of 2019. The agreement contains provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement may be accelerated or extended or the agreement may be terminated early by Goldman Sachs or Humana, and various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our common stock from Goldman Sachs or we may be required to make a payment. If we are obligated to make payment, we may elect to satisfy such obligation in cash or shares of our common stock.

Our remaining repurchase authorization was approximately $1,176 million as of February 21, 2019, excluding the $150 million pending final settlement of our November 28, 2018 ASR.

Excluding shares acquired in connection with employee stock plans, share repurchases were as follows during the years ended December 31, 2018, 2017 and 2016.

		2018		2017		2016	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
				(in millions)			
February 2017	2,250	—	—	9.71	2,250	—	—
December 2017	3,000	3.07	1,024	3.28	800	—	—
Total repurchases		3.07	$1,024	12.99	$3,050	—	$ —

In connection with employee stock plans, we acquired 0.4 million common shares for $116 million in 2018, 0.5 million common shares for $115 million in 2017, and 0.6 million common shares for $104 million in 2016.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.6 billion and $8.0 billion as of December 31, 2018 and 2017, respectively, which exceeded aggregate minimum regulatory requirements of $5.2 billion and $4.8 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2019 is approximately $1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
		(in millions)	
Rent expense	$ 167	$ 204	$ 179
Sublease rental income	(32)	(33)	(26)
Net rent expense	$ 135	$ 171	$ 153

Future annual minimum payments due subsequent to December 31, 2018 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2019	$ 147	$ (13)	$ 134
2020	113	(12)	101
2021	96	(10)	86
2022	79	(9)	70
2023	34	(9)	25
Thereafter	50	(23)	27
Total	$ 519	$ (76)	$ 443

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $240 million in 2019, $201 million in 2020, $136 million in 2021, $98 million in 2022, and $61 million in 2023. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2018, we were not involved in any SPE transactions.

Guarantees and Indemnifications

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our military services subsidiaries and funding to maintain required statutory capital levels of certain regulated subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our Medicare products, which accounted for approximately 80% of our total premiums and services revenue for the year ended December 31, 2018, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2019, and all of our product offerings filed with CMS for 2019 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage, or MA, plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these

providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below, as well as ordinary course reviews of our internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2018, 15% of the risk score was calculated from claims data submitted through EDS. In 2019 and 2020 CMS will increase that percentage to 25% and 50%, respectively. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS and the Office of the Inspector General of Health and Human Services, or HHS-OIG, are continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provided that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample would be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of Medicare FFS (we refer to the process of accounting for errors in FFS claims as the "FFS Adjuster"). This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans' payment rates in order to establish actuarial equivalence in payment rates as required under the Medicare statute. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of our Medicare Advantage plans.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For Service business which we used to represent a proxy of the FFS Adjuster which has not yet been finalized. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. We report the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which we refer to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. We are studying the Proposed Rule and CMS' underlying analysis contained therein. We believe, however, that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and we expect to provide substantive comments to CMS on the Proposed

Rule as part of the notice-and-comment rulemaking process. We are also evaluating the potential impact of the Proposed Rule, and any related regulatory, industry or company reactions, all or any of which could have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk- adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the result of these reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

We believe that CMS' statements and policies regarding the requirement to report and return identified overpayments received by MA plans are inconsistent with CMS' 2012 RADV audit methodology, and the Medicare statute's requirements. These statements and policies, such as certain statements contained in the preamble to CMS’ final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015 (which we refer to as the "Overpayment Rule"), and the Proposed Rule, appear to equate each Medicare Advantage risk adjustment data error with an “overpayment” without addressing the principles underlying the FFS Adjuster referenced above. On September 7, 2018, the Federal District Court for the District of Columbia vacated CMS's Overpayment Rule, concluding that it violated the Medicare statute, including the requirement for actuarial equivalence, and that the Overpayment Rule was also arbitrary and capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has filed a motion for reconsideration related to certain aspects of the Federal District Court's opinion and has simultaneously filed a notice to appeal the decision to the Circuit Court of Appeals.

We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2018, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2018, primarily consisted of the TRICARE T2017 East Region contract replacing the 5-year T3 South Region contract that expired on December 31, 2017. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately 6 million TRICARE beneficiaries, under which delivery of health care services commenced on January 1, 2018. The T2017 East Region contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our state-based Medicaid business accounted for approximately 4% of our total premiums and services revenue for the year ended December 31, 2018. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services (LTSS), and in Illinois for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including reviews by regulatory bodies that may compare our Medicare Advantage profitability to our non-Medicare Advantage business profitability, or compare the profitability of various products within our Medicare Advantage business, and require that they remain within certain ranges of each other, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Legal Proceedings and Certain Regulatory Matters

As previously disclosed, the Civil Division of the United States Department of Justice provided us with an information request in December 2014, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by

us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned *United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by us in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by us under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. We take seriously our obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations since the transfer to the Western District of Kentucky. We have engaged in active discovery with the relator who has pursed the matter on behalf of the United States for the past year, and expect that discovery process to conclude in the near future and for the Court to consider our motion for summary judgment.

On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under Health Care Reform , for years 2014, 2015 and 2016. Our case has been stayed by the Court, pending resolution of similar cases filed by other insurers. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid risk corridor payments as of December 31, 2018. We have fully recognized all liabilities due to the federal government that we have incurred under the risk corridor program, and have paid all amounts due to the federal government as required. There is no assurance that we will prevail in the lawsuit.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business
operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate and payment disputes, including disputes over reimbursement rates required by statute, general contractual matters, intellectual property matters, and challenges to subrogation practices. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the individual may continue to

prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extra contractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

17. SEGMENT INFORMATION

We manage our business with four reportable segments: Retail, Group and Specialty, Healthcare Services, and Individual Commercial. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group Medicare accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health benefits, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE T2017 East Region contract. The Healthcare Services segment includes our services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health, including our investment in Kindred at Home. The Individual Commercial segment consisted of our individual commercial fully-insured medical health insurance business, which we exited beginning January 1, 2018. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies, which were sold in 2018.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana

Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis, including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non-risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non-risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $13.4 billion in 2018, $13.5 billion in 2017, and $13.4 billion in 2016. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $129 million in 2018, $107 million in 2017, and $111 million in 2016.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail and Group and Specialty segment customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2018							
External revenues							
Premiums:							
Individual Medicare Advantage	$ 35,656	$ —	$ —	$ —	$ —	$ —	$ 35,656
Group Medicare Advantage	6,103	—	—	—	—	—	6,103
Medicare stand-alone PDP	3,584	—	—	—	—	—	3,584
Total Medicare	45,343	—	—	—	—	—	45,343
Fully-insured	510	5,444	—	8	—	—	5,962
Specialty	—	1,359	—	—	—	—	1,359
Medicaid and other	2,255	—	—	—	22	—	2,277
Total premiums	48,108	6,803	—	8	22	—	54,941
Services revenue:							
Provider	—	—	404	—	—	—	404
ASO and other	11	835	—	—	4	—	850
Pharmacy	—	—	203	—	—	—	203
Total services revenue	11	835	607	—	4	—	1,457
Total external revenues	48,119	7,638	607	8	26	—	56,398
Intersegment revenues							
Services	—	18	16,840	—	—	(16,858)	—
Products	—	—	6,330	—	—	(6,330)	—
Total intersegment revenues	—	18	23,170	—	—	(23,188)	—
Investment income	136	23	34	—	110	211	514
Total revenues	48,255	7,679	23,811	8	136	(22,977)	56,912
Operating expenses:							
Benefits	40,925	5,420	—	(70)	77	(470)	45,882
Operating costs	5,327	1,810	22,905	4	6	(22,527)	7,525
Depreciation and amortization	270	88	163	—	—	(116)	405
Total operating expenses	46,522	7,318	23,068	(66)	83	(23,113)	53,812
Income from operations	1,733	361	743	74	53	136	3,100
Loss on sale of business	—	—	—	—	—	786	786
Interest expense	—	—	—	—	—	218	218
Other expense, net	—	—	—	—	—	33	33
Income (loss) before income taxes and equity in earnings	1,733	361	743	74	53	(901)	2,063
Equity in net earnings of Kindred at Home	—	—	11	—	—	—	11
Segment earnings (losses)	$ 1,733	$ 361	$ 754	$ 74	$ 53	$ (901)	$ 2,074

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 81% for 2018, compared to 79% for 2017, and 75% for 2016.

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2017							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 32,720	$ —	$ —	$ —	$ —	$ —	$ 32,720
Group Medicare Advantage	5,155	—	—	—	—	—	5,155
Medicare stand-alone PDP	3,702	—	—	—	—	—	3,702
Total Medicare	41,577	—	—	—	—	—	41,577
Fully-insured	478	5,462	—	947	—	—	6,887
Specialty	—	1,310	—	—	—	—	1,310
Medicaid and other	2,571	—	—	—	35	—	2,606
Total premiums	44,626	6,772	—	947	35	—	52,380
Services revenue:							
Provider	—	—	258	—	—	—	258
ASO and other	10	626	—	—	8	—	644
Pharmacy	—	—	80	—	—	—	80
Total services revenue	10	626	338	—	8	—	982
Total revenues—external customers	44,636	7,398	338	947	43	—	53,362
Intersegment revenues							
Services	—	20	17,293	—	—	(17,313)	—
Products	—	—	6,292	—	—	(6,292)	—
Total intersegment revenues	—	20	23,585	—	—	(23,605)	—
Investment income	90	31	35	4	87	158	405
Total revenues	44,726	7,449	23,958	951	130	(23,447)	53,767
Operating expenses:							
Benefits	38,218	5,363	—	544	131	(760)	43,496
Operating costs	4,292	1,590	22,848	201	12	(22,376)	6,567
Merger termination fee and related costs, net	—	—	—	—	—	(936)	(936)
Depreciation and amortization	238	84	143	13	—	(100)	378
Total operating expenses	42,748	7,037	22,991	758	143	(24,172)	49,505
Income (loss) from operations	1,978	412	967	193	(13)	725	4,262
Interest expense	—	—	—	—	—	242	242
Income (loss) before income taxes and equity in earnings	1,978	412	967	193	(13)	483	4,020
Equity in net earnings of Kindred at Home	—	—	—	—	—	—	—
Segment earnings (losses)	$ 1,978	$ 412	$ 967	$ 193	$ (13)	$ 483	$ 4,020

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

	Retail	Group and Specialty	Healthcare Services	Individual Commercial	Other Businesses	Eliminations/ Corporate	Consolidated
				(in millions)			
2016							
Revenues—external customers							
Premiums:							
Individual Medicare Advantage	$ 31,863	$ —	$ —	$ —	$ —	$ —	$ 31,863
Group Medicare Advantage	4,283	—	—	—	—	—	4,283
Medicare stand-alone PDP	4,009	—	—	—	—	—	4,009
Total Medicare	40,155	—	—	—	—	—	40,155
Fully-insured	428	5,405	—	3,064	—	—	8,897
Specialty	—	1,279	—	—	—	—	1,279
Medicaid and other	2,640	12	—	—	38	—	2,690
Total premiums	43,223	6,696	—	3,064	38	—	53,021
Services revenue:							
Provider	—	—	278	—	—	—	278
ASO and other	6	643	1	—	10	—	660
Pharmacy	—	—	31	—	—	—	31
Total services revenue	6	643	310	—	10	—	969
Total revenues—external customers	43,229	7,339	310	3,064	48	—	53,990
Intersegment revenues							
Services	—	22	18,979	—	—	(19,001)	—
Products	—	—	5,993	—	—	(5,993)	—
Total intersegment revenues	—	22	24,972	—	—	(24,994)	—
Investment income	90	25	30	5	66	173	389
Total revenues	43,319	7,386	25,312	3,069	114	(24,821)	54,379
Operating expenses:							
Benefits	36,783	5,233	—	3,301	617	(927)	45,007
Operating costs	4,650	1,727	24,073	601	16	(23,894)	7,173
Merger termination fee and related costs, net	—	—	—	—	—	104	104
Depreciation and amortization	196	82	143	36	1	(104)	354
Total operating expenses	41,629	7,042	24,216	3,938	634	(24,821)	52,638
Income (loss) from operations	1,690	344	1,096	(869)	(520)	—	1,741
Gain on sale of business	—	—	—	—	—	—	—
Interest expense	—	—	—	—	—	189	189
Income (loss) before income taxes and equity in earnings	1,690	344	1,096	(869)	(520)	(189)	1,552
Equity in net earnings of Kindred at Home	—	—	—	—	—	—	—
Segment earnings (losses)	$ 1,690	$ 344	$ 1,096	$ (869)	$ (520)	$ (189)	$ 1,552

Premiums revenue for our Individual Commercial segment for 2016 includes a reduction of $583 million associated with the write-off of commercial risk corridor receivables.

Benefits expense for Other Businesses for 2016 includes $505 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for less than 1% of our consolidated premiums and services revenue for the year ended December 31, 2018 and 2017. We use long-duration accounting for life insurance, annuities, certain health and other supplemental products and, prior to its sale in 2018, long-term care policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). As discussed in Note 2, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model because premiums received in the current year are intended to pay anticipated benefits in that year.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2018 and 2017.

	2018		2017	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 36	$ —	$ 103	$ —
Trade accounts payable and accrued expenses	—	—	—	(56)
Long-term liabilities	—	(219)	—	(2,923)
Total asset (liability)	$ 36	$ (219)	$ 103	$ (2,979)

The decline in the balances of the deferred acquisition costs and future benefits payable reflects the sale of KMG on August 9, 2018. In addition, future policy benefits payable include amounts of $217 million at December 31, 2018 and $199 million at December 31, 2017 which are subject to 100% coinsurance agreements as more fully described in Note 19.

Benefit expense reflects no net increase in future policy benefit payable in 2018, a net reduction of $22 million in 2017 and a net increase of $439 million in 2016. The 2016 amount reflects the net change of $505 million associated with our closed block of long-term care insurance policies, which were sold in 2018 as discussed further below. Amortization of deferred acquisition costs included in operating costs was $48 million in 2018, $71 million in 2017, and $67 million in 2016.

All three years include the effect of the release of reserves and accelerating deferred acquisition amortization costs of existing previously underwritten individual commercial medical members transitioning to policies compliant with the Health Care Reform Law. Deferred acquisition costs included $3 million associated with our individual commercial

medical policies at December 31, 2017. Future policy benefits payable associated with our individual commercial medical policies were $19 million at December 31, 2017. There were no remaining balances at December 31, 2018. We have exited our individual commercial medical business effective January 1, 2018.

Future policy benefits payable included $2.3 billion at December 31, 2017 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. As described in Note 3, on August 9, 2018, we completed the sale of KMG. Future policy benefits payable included amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was additional liability of $168 million at December 31, 2017. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provided nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual premium rate increase, interest, morbidity, mortality, persistency, and maintenance expense assumptions from those assumed in our reserves were particularly significant to our closed block of long-term care insurance policies. We monitored the loss experience of these long-term care insurance policies and, when necessary, applied for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience varied from our loss recognition date assumptions, material adjustments to reserves were required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets. During 2017, we performed loss recognition testing comparing our existing future policy benefits payable with the present value of future gross premiums associated with our closed block of long-term care insurance policies and determined that no premium deficiency existed at December 31, 2017.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, annuities in run-off status and, prior to its sale in 2018, long-term care, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods

used to determine future policy benefits payable as detailed in Note 2. Reinsurance recoverables, included in other current and long-term assets, were $314 million at December 31, 2018 and $824 million at December 31, 2017. The decline in the balances reflects the sale of KMG on August 9, 2018. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 99% at December 31, 2018 and approximately 33% at December 31, 2017. Premiums ceded were $976 million in 2018, $969 million in 2017 and $842 million in 2016. Benefits ceded were $980 million in 2018, $844 million in 2017, and $767 million in 2016. Ceded premium and benefits reflect the activity associated with ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of our reinsurers on a regular basis. Protective Life Insurance Company with $177 million in reinsurance recoverables is well-known and well-established with a AM Best rating of A+ (superior) at December 31, 2018 . The remaining reinsurance recoverables of $137 million are divided between 10 other reinsurers, with $110 million subject to funds withheld accounts or other financial guarantees supporting the repayment of these amounts.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Humana Inc. and its subsidiaries (the "Company") as of December 31, 2018 and 2017, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2018, including the related notes and financial statement schedules listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017**,** and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in

accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 21, 2019

We have served as the Company's auditor since 1968.

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2018 and 2017 follows:

	2018			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 14,279	$ 14,259	$ 14,206	$ 14,168
Income before income taxes and equity in net earnings	707	19	901	436
Net income	491	193	644	355
Basic earnings per common share	$ 3.56	$ 1.40	$ 4.68	$ 2.60
Diluted earnings per common share (1)	$ 3.53	$ 1.39	$ 4.65	$ 2.58

	2017			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 13,762	$ 13,534	$ 13,282	$ 13,189
Income before income taxes	1,689	1,042	799	490
Net income	1,115	650	499	184
Basic earnings per common share (1)	$ 7.54	$ 4.49	$ 3.46	$ 1.30
Diluted earnings per common share (1)	$ 7.49	$ 4.46	$ 3.44	$ 1.29

(1) The calculation of earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2018, we as the principal executive officer, the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2018, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2018 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 134.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2019, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	56	President and Chief Executive Officer, Director	12/11	(1)
Vishal Agrawal, M.D.	44	Chief Strategy and Corporate Development Officer	12/18	(2)
Roy A. Beveridge, M.D.	61	Chief Medical Officer	06/13	(3)
Elizabeth D. Bierbower	60	Segment President	03/17	(4)
Jody L. Bilney	57	Chief Consumer Officer	04/13	(5)
Sam M. Deshpande	54	Chief Risk Officer	07/17	(6)
William K. Fleming, PharmD	51	Segment President, Healthcare Services	03/17	(7)
Christopher H. Hunter	50	Segment President, Group Business	01/14	(8)
Timothy S. Huval	52	Chief Human Resources Officer	12/12	(9)
Brian A. Kane	46	Chief Financial Officer	06/14	(10)
Brian P. LeClaire	58	Chief Information Officer	08/11	(11)
Joseph C. Ventura	42	Chief Legal Officer and Corporate Secretary	02/19	(12)
T. Alan Wheatley	51	Segment President, Retail	03/17	(13)
Cynthia H. Zipperle	56	Senior Vice President and Chief Accounting Officer	12/14	(14)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Dr. Agrawal serves as Chief Strategy and Corporate Development Officer, having joined the company in December 2018. Prior to joining the company, Dr. Agrawal was Senior Advisor for The Carlyle Group L.P., having held that position from October 2017 to December 2018. Previously, Dr. Agrawal was President and Chief Growth Officer of Ciox Health, the largest health information exchange and release of information services

organization in the U.S. from December of 2015 to October 2018. Prior to joining Ciox Health, Dr. Agrawal served as President of Harris Healthcare Solutions from January 2013 to December 2015.

(3) Dr. Beveridge currently serves as Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(4) Ms. Bierbower currently serves as Segment President, having held this position since August 2018. She is responsible for creating a new operating model and member experience that reduces friction in the system and helps members engage in and manage their health. Prior to that, she served as the Segment President, Group Business, and also previously led the Company's Specialty Benefits area, including dental, vision, life, disability and workplace voluntary benefits. Ms. Bierbower joined the Company in 2001.

(5) Ms. Bilney currently serves as Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(6) Mr. Deshpande currently serves as Chief Risk Officer, having held this position since joining the Company in July 2017. Before joining Humana, Mr. Deshpande spent 17 years at Capital One in key leadership positions, most recently as Business Chief Risk Officer for the U.S. and international card business. He previously served as the Business Chief Risk Officer and Head of Enterprise Services for the Financial Services Division, responsible for Business Risk, Data Science, Data Quality, Process Excellence and Project Management. He also led marketing and analysis for the Home Loans, Auto Finance, and Credit Card businesses, with responsibilities for business strategy, credit, product and marketing.

(7) Mr. Fleming currently serves as Segment President, Healthcare Services, where he is responsible for Humana's clinical and pharmacy businesses that service all Humana segments, having held this position since March of 2017. Prior to that, he served as President of the Company's pharmacy business. Mr. Fleming joined the Company in 1994.

(8) Mr. Hunter currently serves as Segment President, Group Business, having held this position since August 2018. Prior to that, he served as Chief Strategy Officer from joining the company in January 2014 until August 2018. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(9) Mr. Huval currently serves as Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(10) Mr. Kane currently serves as Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(11) Mr. LeClaire currently serves as Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(12) Mr. Ventura currently serves as Chief Legal Officer and Corporate Secretary. He joined the Company in January 2009 and since then has held various positions of increasing responsibility in the Company's Law Department, including most recently, Senior Vice President, Associate General Counsel & Corporate Secretary from July 2017 until February 2019.

(13) Mr. Wheatley currently serves as Segment President, Retail, having held this position since March 2017. During his 25-year career with the Company, Mr. Wheatley has served in a number of key leadership roles, including Vice President of Medicare Service Operations and President of the East Region, one of the Company's key Medicare geographies.

(14) Mrs. Zipperle currently serves as Senior Vice President, Chief Accounting Officer, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com, and any waiver of the application of the Ethics Every Day with respect to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;

- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2018 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	677,648	$ 213.171	4,673,360	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	677,648	$ 213.171	4,673,360	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.
(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) Of the number listed above, 2,040,768 can be issued as restricted stock at December 31, 2018 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions "Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Security Ownership of Directors and Executive Officers" in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 18, 2019 appearing under the caption "Audit Committee Report" of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Condensed Financial Information at December 31, 2018 and 2017 and for the years ended December 31, 2018, 2017 and 2016
Schedule II	Valuation and Qualifying Accounts for the years ended December 31, 2018, 2017 and 2016

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) Humana Inc. Amended and Restated By-Laws of Humana Inc., effective as of December 14, 2017 (incorporated herein by reference to Exhibit 3(b) to Humana Inc.'s Current Report on Form 8-K filed on December 14, 2017).

4(a) Indenture, dates as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, File No. 001-05975).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006, File No.001-05975).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(f) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006, Req. No. 333-132878).

(g)	There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.
(h)	Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).
(i)	Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).
(j)	Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(k)	Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(l)	Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).
(m)	Tenth Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017.
(n)	Eleventh Supplemental Indenture, dated March 16, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on March 16, 2017.
(o)	Twelfth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017.
(p)	Thirteenth Supplemental Indenture, dated December 21, 2017, between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on December 21, 2017.
10(a)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(b)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(c)*	Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 21, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).
(d)*	Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999, File No. 001-05975).
(e)*	The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(f)*†	Humana Inc. Executive Severance Policy, effective as of March 1, 2019.
(g)*	Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).
(h)*	Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 18, 2011).
(i)*	Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994, File No. 001-05975).
(j)*	Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).
(k)*	Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).
(l)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(m)*	Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.
(n)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(o)	Five-Year $2 Billion Amended and Restated Credit Agreement , dated as of May 22, 2017, among Humana Inc., and JPMorgan Chase Bank, N.A. as Agent and as CAF Loan Agent, Bank of America, N.A. as Syndication Agent, Citibank, N.A., PNC Bank, National Association, U.S. Bank National Association, and Wells Fargo Bank, National Association, as Documentation Agents, and J.P. Morgan Chase Bank, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citigroup Global Markets, Inc., PNC Capital Markets LLC, U.S. Bank National Association, and Wells Fargo Securities, LLC, as Joint-Lead Arrangers and Joint Bookrunners (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on May 22, 2017).
(p)	Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(q)	Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(r)	Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(s)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(t)	Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).
(u)	Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, File No. 001-05975).

(v)	Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005, File No. 001-05975).
(w)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(x)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(y)*	Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).
(z)*	Amendment No. 2, dated as of August 16, 2018, to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated as of February 27, 2014 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.s Current Report on Form 8-K, filed on August 20, 2018).
(aa)*†	Humana Inc. Change in Control Policy, effective March 1, 2019.
(bb)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 7, 2014).
(cc)	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(dd)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).
(ee)*	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K filed on February 16, 2018).
(ff)*†	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions).
(gg)*†	Form of Company's Restricted Stock Unit Agreement with Performance Vesting and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan.
(hh)*†	Form of Company's Incentive Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan.
(ii)*†	Form of Company's Stock Option Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (Non-Qualified Stock Options).
(jj)*†	Humana Inc. Compensation Recoupment Policy, effective February 21, 2019.
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).

31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.
101	The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2018 and 2017; (ii) the Consolidated Statements of Income for the years ended December 31, 2018, 2017 and 2016; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017 and 2016; (iv) the Consolidated Statements of Stockholders’ Equity as of December 31, 2018, 2017, and 2016; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(n), and Exhibits 10(w) through and including 10(aa), as well as Exhibits 10(cc) through and including Exhibit 10(jj) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Exchange Act, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2018	2017
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 265	$ 383
Investment securities	313	305
Receivable from operating subsidiaries	1,306	1,042
Other current assets	628	245
Total current assets	2,512	1,975
Property and equipment, net	1,209	1,091
Investments in subsidiaries	16,951	16,810
Equity method investment in Kindred at Home	1,047	—
Other long-term assets	359	426
Total assets	$ 22,078	$ 20,302
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 4,487	$ 4,311
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	38	41
Short-term debt	1,694	150
Other current liabilities	791	896
Total current liabilities	7,038	5,426
Long-term debt	4,375	4,770
Other long-term liabilities	504	264
Total liabilities	11,917	10,460
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,594,841 shares issued at December 31, 2018 and 198,572,458 shares issued at December 31, 2017	33	33
Capital in excess of par value	2,535	2,445
Retained earnings	15,072	13,670
Accumulated other comprehensive income (loss)	(159)	19
Treasury stock, at cost, 63,028,169 shares at December 31, 2018 and 60,893,762 shares at December 31, 2017	(7,320)	(6,325)
Total stockholders' equity	10,161	9,842
Total liabilities and stockholders' equity	$ 22,078	$ 20,302

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Revenues:			
Management fees charged to operating subsidiaries	$ 1,666	$ 1,864	$ 1,683
Investment and other income, net	30	57	42
	1,696	1,921	1,725
Expenses:			
Operating costs	1,468	1,801	1,519
Merger termination fee and related costs, net	—	(936)	104
Depreciation	342	332	302
Interest	218	243	189
	2,028	1,440	2,114
Other expense, net	33	—	—
Loss on sale of business	782	—	—
(Loss) income before income taxes and equity in net earnings of subsidiaries	(1,147)	481	(389)
(Benefit) provision for income taxes	(542)	61	(107)
(Loss) income before equity in net earnings of subsidiaries	(605)	420	(282)
Equity in net earnings of subsidiaries	2,277	2,028	896
Equity in net earnings of Kindred at Home	11	—	—
Net income	$ 1,683	$ 2,448	$ 614

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Net income	$ 1,683	$ 2,448	$ 614
Other comprehensive income (loss):			
Change in gross unrealized investment losses/gains	(189)	149	(101)
Effect of income taxes	51	(55)	38
Total change in unrealized investment gains/losses, net of tax	(138)	94	(63)
Reclassification adjustment for net realized gains included in investment income	(53)	(14)	(96)
Effect of income taxes	17	5	35
Total reclassification adjustment, net of tax	(36)	(9)	(61)
Other comprehensive (loss) income, net of tax	(174)	85	(124)
Comprehensive income attributable to our equity method investment in Kindred at Home	(4)	—	—
Comprehensive income	$ 1,505	$ 2,533	$ 490

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2018	2017	2016
	(in millions)		
Net cash provided by operating activities	$ 2,719	$ 2,423	$ 1,848
Cash flows from investing activities:			
Acquisitions, net of cash acquired	(354)	—	—
Acquisitions, equity method investment in Kindred at Home	(1,095)	—	—
Capital contributions to operating subsidiaries	(697)	(695)	(895)
Purchases of investment securities	(145)	(53)	(151)
Proceeds from sale of investment securities	35	—	25
Maturities of investment securities	59	51	143
Purchases of property and equipment, net	(465)	(359)	(382)
Net cash used in investing activities	(2,662)	(1,056)	(1,260)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	—	1,779	—
Proceeds from issuance (repayments) of commercial paper, net	485	(153)	(2)
Proceeds from term loan	1,000	—	—
Repayment of term loan	(350)	—	—
Repayment of long-term debt	—	(800)	—
Change in book overdraft	(3)	3	5
Common stock repurchases	(1,090)	(3,365)	(104)
Dividends paid	(265)	(220)	(177)
Proceeds from stock option exercises and other	48	62	11
Net cash used in financing activities	(175)	(2,694)	(267)
(Decrease) increase in cash and cash equivalents	(118)	(1,327)	321
Cash and cash equivalents at beginning of year	383	1,710	1,389
Cash and cash equivalents at end of year	$ 265	$ 383	$ 1,710

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by our parent company in the event of insolvency for: (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent has also guaranteed the obligations of our military services subsidiaries and funding to maintain required statutory capital levels of certain other regulated subsidiaries.

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an extraordinary dividend requiring prior regulatory approval. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.6 billion and $8.0 billion as of December 31, 2018 and 2017, respectively, which exceeded aggregate minimum regulatory requirements of $5.2 billion and $4.8 billion, respectively. The amount of ordinary dividends that may be paid to our parent company in 2019 is approximately $1 billion in the aggregate. The amount, timing and mix of ordinary and extraordinary dividend payments will vary due to state regulatory requirements, the level of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Actual dividends that were paid to our parent company were approximately $2.3 billion in 2018, $1.4 billion in 2017, and $0.8 billion in 2016.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. During 2018, 2017 and 2016, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2018, 2017, and 2016
(in millions)

	Balance at Beginning of Period	Acquired/(Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2018	$ 96	$ —	$ 36	$ (29)	$ (24)	$ 79
2017	118	—	20	(10)	(32)	96
2016	101	—	39	19	(41)	118
Deferred tax asset valuation allowance:						
2018	(49)	—	(5)	—	—	(54)
2017	(49)	—	—	—	—	(49)
2016	(42)	—	(7)	—	—	(49)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

Date: February 21, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Chief Financial Officer (Principal Financial Officer)	February 21, 2019
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 21, 2019
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 21, 2019
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 21, 2019
/s/ FRANK BISIGNANO **Frank Bisignano**	Director	February 21, 2019
/s/ KAREN DESALVO MD, MPH, MSc **Karen DeSalvo, MD, MPH, MSc**	Director	February 21, 2019
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 21, 2019
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 21, 2019
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 21, 2019
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 21, 2019
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 21, 2019
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 21, 2019
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 21, 2019
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 21, 2019

Exhibit 10(aa)

HUMANA INC.

CHANGE IN CONTROL POLICY

This Humana Inc. Change in Control Policy (this "Policy") has been adopted by the Organization & Compensation Committee (the "Committee") of the Board of Directors of the Company to avoid the departure of and provide protection to Executives in the event of a Change in Control in order that they may act in the best interest of all shareholders and to reinforce and encourage their continued attention and dedication to their duties without the distraction and concern for the uncertainty that would result from the effects a Change in Control would have on their personal situations. This Policy shall be effective as of the Effective Date as provided herein, and shall apply to all Executives (as defined herein).

Section 1. Definitions. For purposes of this Policy, the following terms shall have the following meaning:

"Annual Base Salary" shall mean an Executive's stated annual compensation without regard to any bonus, perquisite or other benefits.

"Board" means the Board of Directors of the Company.

"Cause" shall mean a termination by reason of the conviction of Executive, by a court of competent jurisdiction and following the exhaustion of all possible appeals, of a criminal act involving the Company or its assets.

"CEO" shall mean the Company's President and Chief Executive Officer.

"CEO Direct Reports" shall mean Executive Officers of the Company who are direct reports to the Company's President and Chief Executive Officer.

"Change in Control" shall have the meaning set forth in Exhibit A.

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Company" means Humana Inc., a Delaware corporation, and any successor thereto.

"Compensation Committee" means the Organization and Compensation Committee of the Board.

"Date of Termination" shall mean the date specified in the Notice of Termination, not to exceed thirty (30) days from the date such Notice of Termination is given, or as otherwise agreed to by Executive and the Company.

"Executive" shall mean all eligible employees, which includes the CEO Direct Reports, other Executive Officers, and such other individuals as identified by the Compensation Committee who do not have separate agreements or arrangements that provide for payments and/or benefits upon a Change in Control (other than equity related agreements or arrangements).

"Executive Officer" shall include those executive officers designated by the Board under Rule 16a-1(f) under the Securities Exchange Act of 1934, as amended.

"Good Reason" shall mean the occurrence after a Change in Control of any of the following events without Executive's express written consent:

(i) Any material reduction in Executive's title, authority or responsibilities, including reporting responsibilities;

(ii) A reduction by the Company in Executive's Annual Base Salary as in effect on the date of the Change in Control or as the same may be increased from time to time;

(iii) The relocation of Executive's office at which Executive is to perform his or her duties to a location more than thirty (30) miles from the location at which Executive performed his or her duties prior to the Change in Control;

(iv) The failure by the Company to continue in effect any incentive, bonus or other compensation plan in which Executive participates, unless the Company substitutes a substantially equivalent benefit;

(v) The failure by the Company to continue in effect any Executive benefit plan (including any medical, hospitalization, life insurance, dental or disability benefit plan in which Executive participated) or any material fringe benefit or perquisite enjoyed by Executive at the time of the Change in Control, unless the Company substitutes benefits which, in the aggregate, are equivalent; or

(vi) The failure of the Company to obtain a satisfactory agreement from any successor or assign of the Company to assume and agree to perform this Policy.

A termination of employment by the Executive for Good Reason shall only be effectuated after giving the Company written notice of the termination, setting forth the conduct of the Company that constitutes Good Reason, within 30 days of the first date on which the Executive has knowledge of such conduct. The Executive shall further provide the Company with at least 30 days following the date on which such written notice is provided to cure such conduct. If the Company fails to cure such conduct, a termination of employment by the Executive for Good Reason shall be effective on the day following the expiration of such 30-day cure period.

"Effective Date" means March 1, 2019, which is the date that this Policy is effective.

"Exchange Act" means the Securities Exchange Act of 1934, and any successor statute, as it may be amended from time to time.

"Notice of Termination" shall mean a notice which shall indicate the specific termination provision in this Policy which is relied upon and shall set forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of Executive's employment under the provision so indicated. Any purported termination by the Company or by Executive hereunder shall not be effective until communicated by written Notice of Termination to the other party.

"Payments" means any payment or distribution of any type to Executive or for Executive's benefit by the Company, any affiliate of the Company, any Person who acquires ownership or effective control of the Company or ownership of a substantial portion of the Company's assets (within the meaning of Section 280G of the Code and the regulations thereunder), or any affiliate of such Person, whether paid or payable or distributed or distributable pursuant to the terms of this Policy or otherwise.

"Person" means any individual, corporation, partnership, limited liability company, association, trust or other entity or organization, including a government or political subdivision or an agency or instrumentality thereof.

"Qualifying Termination" means (i) by the Company other than for Cause, or by Executive for Good Reason within twenty-four (24) months following a Change in Control and during the term of this Policy, or (ii) by the Company other than for Cause at any time prior to the date of a Change in Control and such termination occurred after the Company entered into a definitive agreement, the consummation of which would constitute a Change in Control.

"Section 409A" shall mean Section 409A of the Code.

"Separation from Service" means a termination of the employment relationship of Executive with the Company or an affiliate within the meaning of Section 409A and Treasury Regulation section 1.409A-1(h) or any successor thereto.

"Severance Multiple" means (i) for the CEO, two and a half (2.5) times, (ii) for CEO Direct Reports, two (2) times, and (iii) for other Executives, no greater than one and a half (1.5) times.

"Severance Period" means (i) for the CEO, thirty (30) months, (ii) for CEO Direct Reports, twenty-four (24) months, and (iii) for other Executives, no greater than eighteen (18) months or such other period as the Committee shall determine.

"Severance Rate" means an amount equal to the sum of (A) Executive's Annual Base Salary at the greater of the rate in effect at the time the Change in Control occurred, if applicable, or when the Notice of Termination was given plus (B) the target annual bonus or incentive compensation which could have been earned by Executive (including, but not limited to, any target sales incentive compensation, to the extent applicable) calculated as if all relevant goals had been met during the then-current fiscal year of the Company pursuant to the terms of the incentive compensation plan in which Executive participates. With respect to clause (B), If there

is no incentive compensation plan in effect at the time the Notice of Termination is given, then for purposes of clause (B) hereof it shall be assumed that the amount of incentive compensation to be paid to Executive shall be the target amount under any incentive compensation plan in which Executive participated at the date of the Change in Control, if applicable, or the most recent plan participated in, whichever would be greater.

Section 2. Benefits.

(a) In the event of a Qualifying Termination, subject to Sections 3(d), 4 and 5 hereof, the Company shall pay to Executive in a lump sum within fifteen (15) business days after the Date of Termination:

(i) Executive's base salary earned but not yet paid through the Date of Termination at the greater of the rate in effect at the time the Change in Control occurred, if applicable, or when the Notice of Termination was given, plus any bonuses or incentive compensation which, pursuant to the terms of any compensation or benefit plan, have been earned and are payable as of the Date of Termination, but have not actually been paid by the Date of Termination. For purposes of this Policy, bonuses and incentive compensation shall be considered payable if all conditions for earning them have been met and any requirement that Executive be actively employed as of the date of payment shall be disregarded;

(ii) A lump sum in an amount equal to (x) the applicable Severance Multiple for such Executive multiplied by (y) the Severance Rate.

(b) In addition, in the event of a Qualifying Termination the Company shall, for the period stated below, maintain in full force and effect for the benefit of Executive and Executive's dependents and beneficiaries, at the Company's expense, all life insurance, health insurance, dental insurance, accidental death and dismemberment insurance and disability insurance under plans and programs in which Executive and/or Executive's dependents and beneficiaries participated immediately prior to the Consummation of the Change in Control, provided that continued participation is possible under the general terms and provisions of such plans and programs (the "Extended Benefits"). The Extended Benefits shall be continued until the earlier of (A) the end of the applicable Severance Period for such Executive, and (B) the effective date of Executive's coverage under equivalent benefits from a new employer (provided that no such equivalent benefits shall be considered effective unless and until all pre-existing condition limitations and waiting period restrictions have been waived or have otherwise lapsed). If participation in any such plan or program is barred, the Company shall arrange at its own expense to provide Executive with benefits substantially similar to those which Executive would have been entitled to receive under such plans and programs. At the end of the period of coverage, Executive shall have the right to have assigned to him or her, at no cost and with no apportionment of prepaid premiums, any assignable insurance policy relating specifically to him or her. At the conclusion of the coverage provided under this Section 3(b), Executive shall be entitled to the continuation for a period of 18 months of the health and dental insurance then being provided to him or her at a cost to him or her equal to the amount then being charged to employees of the Company for such coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA). The coverage provided pursuant to this Subsection shall be in satisfaction of the Company's

obligation to provide coverage under COBRA. The Company will use all commercially reasonable efforts to provide for the continuation of benefits in a manner that (A) does not subject the benefits to Section 409A and (B) does not cause the benefits to be included in the taxable income of Executive.

(c) In addition, upon a Qualifying Termination of employment, the Company will (i) provide an Executive who is the CEO or a CEO Direct Report with financial planning services during the one year period immediately following the Date of Termination on the same terms as the financial planning services were provided to such Executive immediately prior to the Change in Control and (ii) provide eligible individuals with outplacement services through an outplacement firm of the Company's choosing at a level of services to be determined by the Company, with such services to extend until the earlier of (A) twelve months following the Date of Termination for the CEO or CEO Direct Reports, or six months following the Date of Termination for other Executives, or (B) the date Executive secures full time employment.

(d) Benefits under this Policy shall not be duplicative of, and shall be offset by, the same type of benefit payable under an agreement between the Company and Executive or another plan, program or arrangement of the Company covering Executive. To the extent that benefits under this Policy are the same type of benefit payable under such agreement or plan, program or arrangement which is subject to, and not exempt from, the requirements of Section 409A, then the benefits payable under this Policy shall be payable at the same time and in the same form as the benefits payable under such agreement or plan, program or arrangement, but only to the extent that such other benefits are subject to and not exempt from Section 409A.

Section 3. 280G Considerations. Notwithstanding anything to the contrary contained in this Policy, (a) to the extent that any Payments constitute "parachute payments" (within the meaning of Section 280G of the Code), and if (b) such aggregate Payments would, if reduced by all federal, state and local taxes applicable thereto (including the excise tax imposed under Section 4999 of the Code (the "Excise Tax")), be less than the amount that Executive would receive, after all taxes, if Executive received aggregate Payments equal (as valued under Section 280G of the Code) to only three times Executive's "base amount" (within the meaning of Section 280G of the Code), less $1.00, then (c) such Payments will be reduced (but not below zero) if and to the extent necessary so that no Payments to be made or benefit to be provided to Executive will be subject to the Excise Tax. All determinations required to be made pursuant to this letter agreement will be made by a nationally recognized accounting firm selected by the Company (the "Accounting Firm"), which will provide detailed supporting calculations (which will include specific information about each Payment (including the amount of each Payment)). For purposes of making the calculations required by this Section 4, the Accounting Firm may make reasonable assumptions and approximations concerning applicable taxes and may rely on reasonable, good faith interpretations concerning the application of Sections 280G and 4999 of the Code. Executive and the Company will furnish to the Accounting Firm such information and documents as the Accounting Firm may reasonably request in order to make a determination under this letter agreement. The Company will bear all costs and make all payments for the Accounting Firm's services relating to any calculations contemplated by this Section 4 and any such determination by the Accounting Firm will be binding upon Executive and the Company. If a determination is made to reduce the Payments, the Company will reduce or eliminate the Payments (i) by first reducing or eliminating the portion of the Payments relating to the provision of outplacement services, (ii)

then by reducing or eliminating cash payments (other than cash payments that are subject to clause (iv) hereof), (iii) then by reducing or eliminating the portion of the Payments which are not payable in cash and are attributable to equity awards (other than that portion of such Payments that are subject to clause (iv) hereof), and (iv) then by reducing or eliminating the portion of the Payments (whether payable in cash or not payable in cash) to which Treasury Regulation § 1.280G-1 Q/A 24(c) applies, in each case in reverse order beginning with payments or benefits which are to be paid the latest in time. It is possible that, after the determinations and selections pursuant to this letter agreement are made, Executive will receive Payments that are, in the aggregate, either more or less than the amount that should have been provided (hereafter referred to as an "Excess Payment" or "Underpayment," respectively). If it is established, pursuant to a final determination of a court or an Internal Revenue Service proceeding that has been finally and conclusively resolved, that an Excess Payment has been made, then Executive will promptly pay an amount equal to the Excess Payment to the Company. In the event that it is determined (i) by a final determination of a court or (ii) by the Accounting Firm upon request by either Executive or the Company, that an Underpayment has occurred, the Company will promptly pay an amount equal to the Underpayment to Executive.

Section 4. Restrictive Covenants. In consideration of Executive's employment by the Company and the rights and benefits of Executive provided by this Policy, Executive will enter into agreements that contain certain covenants regarding non-competition, non-solicitation, non-disparagement and specific enforcement with the restricted period for the non-competition and non-solicitation covenants to be the applicable Severance Period for such Executive, commencing upon the Date of Termination, with such covenants to be substantially in the form attached as Exhibit B hereto.

Section 5. Administration. The Compensation Committee is responsible for the administration of this Policy and shall have all powers and duties necessary to fulfill its responsibilities. The Compensation Committee shall determine any and all questions of fact, resolve all questions of interpretation of the Policy which may arise, and exercise all other powers and discretion necessary to be exercised under the terms of the Policy which it is herein given or for which no contrary provision is made. The Compensation Committee shall have full power and discretion to interpret the Policy and related documents, to resolve ambiguities, inconsistencies and omissions, to determine any question of fact, and to determine the rights and benefits, if any, of any Executive or other employee, in accordance with the provisions of the Policy. The Compensation Committee's decision with respect to any matter shall be final and binding on all parties concerned. The validity of any such interpretation, construction, decision, or finding of fact shall not be given de novo review if challenged in court, by arbitration, or in any other forum, and shall be upheld unless clearly arbitrary or capricious. The Compensation Committee may, from time to time, by action of its appropriate officers, delegate to designated persons or entities the right to exercise any of its powers or the obligation to carry out its duties under the Policy.

Section 6. Section 409A

(a) Compliance. To the extent applicable, it is intended that this Policy comply with the provisions of Section 409A, so as to prevent inclusion in gross income of any amounts payable or benefits provided hereunder in a taxable year that is prior to the taxable year or years in which such amounts or benefits would otherwise actually be distributed, provided or

otherwise made available to Executive. This Policy shall be construed, administered, and governed in a manner consistent with this intent. If and to the extent that any payment or benefit under this Policy is determined by the Company to constitute "non-qualified deferred compensation" subject to Section 409A and is payable to Executive by reason of Executive's termination of employment, then such payment or benefit shall be made or provided to Executive only upon a Separation from Service as defined for purposes of Section 409A. Each severance payment under this Policy will be considered a "separate payment" and not one of a series of payments for purposes of Section 409A. To the extent that any benefits to be provided to Executive pursuant to this Policy are considered nonqualified deferred compensation and are reimbursements subject to Treasury Regulation Section 1.409A-3(i)(1)(iv), then (i) the reimbursement of eligible expenses related to such benefits shall be made on or before the last day of Executive's taxable year following Executive's taxable year in which the expense was incurred and (ii) notwithstanding anything to the contrary in this Policy or any plan providing for such benefits, the amount of expenses eligible for reimbursement during any taxable year of Executive shall not affect the expenses eligible for reimbursement in any other taxable year. Nothing in this Policy will provide a basis for any person to take action against the Company or its affiliates based on matters covered by Section 409A and in no event will the Company or its affiliates be liable for any additional tax, interest or penalties that may be imposed on Executive under Section 409A or any damages for failing to comply with Section 409A.

(b) Six Month Delay for Specified Executives. To the extent that any amount payable or benefit to be provided under this Policy constitutes a nonexempt "nonqualified deferred compensation plan" (as defined in Section 409A) upon a Separation from Service, and to the extent an Executive is deemed to be a "specified employee" (as that term is defined in Section 409A and pursuant to procedures established by the Company) on the Date of Termination, notwithstanding any other provision in this Policy to the contrary, such payment or benefit provision will not be made to Executive during the six month period immediately following the Date of Termination. Instead, on the first business day of the seventh month following the Date of Termination, all amounts that otherwise would have been paid or provided to Executive during the six month period, but were not paid or provided because of this Section 7(b), will be paid or provided to Executive at such time without interest. This six month delay will cease to be applicable if Executive incurs a Separation from Service due to death or if Executive dies before the six month period has expired.

Section 7. Amendment and Termination.

(a) This Policy may be amended by the Compensation Committee at any time, or the Compensation Committee may determine at any time that any Executive is no longer eligible to receive benefits under this Policy; provided, however, that any such amendment or determination of eligibility that would adversely affect an Executive will not be applicable without such Executive's consent until the later of (i) one year following the date of such amendment, and (ii) two years following consummation of a transaction that constitutes a Change of Control if a definitive agreement pertaining to such transaction was entered into prior to the date of such amendment.

(b) This Policy shall continue indefinitely after the Effective Date, unless the Compensation Committee shall decide to terminate this Policy by adopting resolutions

terminating this Policy; provided, however, that any such termination of the Policy shall (i) not be effective until the first anniversary after the action to terminate the Policy is taken by the Compensation Committee and (ii) not affect any payments or benefits already owed to Executive pursuant to the terms of the Policy at the time the termination of the Policy becomes effective.

Section 8. Miscellaneous.

(a) The Company shall pay all reasonable legal fees and related expenses (including the costs of experts, evidence and counsel) incurred by Executive as a result of Executive seeking to obtain or enforce any right or benefit provided by this Policy, provided the Executive is successful on at least one material claim to obtain or enforce such rights or benefits. The reimbursement of the eligible expense must be made on or before the last day of Executive's taxable year following Executive's taxable year in which it was determined that such expense was incurred reimbursable.

(b) This Policy shall be binding upon any successor in interest of the Company or an affiliate (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business or assets of the Company, and shall be enforceable by or on behalf of an Executive in the same manner and to the same extent as the Company is bound and as if no succession had taken place. As used in this Policy, the term "Company" shall include any successor to all or substantially all its business or assets or which becomes bound by the terms of this Policy by the terms hereof, by operation of law, or otherwise. It is intended that this Policy confer vested and nonforfeitable rights for each Executive to receive benefits to which Executive is entitled under the terms of this Policy with Executives being third party beneficiaries.

(c) Except as otherwise provided herein, this Policy shall not affect any Executive's rights or entitlement to other accrued but unpaid compensation or benefits under any other employee benefit program offered to Executive by the Company or an affiliate as of the Date of Termination.

(d) The various provisions of this Policy are severable and any determination of invalidity or unenforceability of any one provision shall not have any effect on the remaining provisions.

(e) For the purposes of this Policy, notices and all other communications provided for in the Policy shall be in writing and shall be deemed to have been duly given when personally delivered or sent by electronic mail or certified mail, return receipt requested, postage prepaid, addressed to the respective addresses last given by each party to the other, provided that all notices to the Company shall be directed to the attention of the Chief Human Resources Officer and Corporate Secretary of the Company. All notices and communications shall be deemed to have been received on the date of delivery thereof or on the third business day after the mailing thereof, except that notice of change of address shall be effective only upon receipt.

(f) Executive shall not be required to mitigate the amount of any payment provided under this Policy by seeking other employment or otherwise, nor shall the

amount of any payment provided under this Policy be reduced by any earnings of Executive after the Date of Termination from any subsequent employer or from any other source.

(g) All payments made pursuant to this Policy shall be subject to withholding of required income and employment taxes.

(h) This Policy shall be governed by and construed in accordance with the internal laws of the State of Kentucky.

Exhibit A

"Change in Control" shall mean the occurrence of:

1) An acquisition (other than directly from the Company) of any voting securities of the Company (the "Voting Securities") by any "Person" (as the term person is used for purposes of Section 13(d) or 14(d) of the Exchange Act), immediately after which such Person has "Beneficial Ownership" (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of twenty percent (20%) or more of the combined voting power of the Company's then outstanding Voting Securities; provided, however, in determining whether a Change in Control has occurred, Voting Securities which are acquired in a "Non-Control Acquisition" (as hereinafter defined) shall not constitute an acquisition which would cause a Change in Control. A "Non-Control Acquisition" shall mean an acquisition by (i) an employee benefit plan (or a trust forming a part thereof) maintained by (A) the Company or (B) any corporation or other Person of which a majority of its voting power or its equity securities or equity interest is owned, directly or indirectly, by the Company (for purposes of this definition, a "Subsidiary") (ii) the Company or its Subsidiaries, or (iii) any Person in connection with a "Non-Control Transaction" (as hereinafter defined);

2) The individuals who, as of the Effective Date are members of the Board (the "Incumbent Board"), cease for any reason to constitute at least two-thirds of the members of the Board; provided, however, that if the election, or nomination for election by the Company's common stockholders, of any new director was approved by a vote of at least two-thirds of the Incumbent Board, such new director shall, for purposes of this Policy, be considered as a member of the Incumbent Board; provided further, however, that no individual shall be considered a member of the Incumbent Board if such individual initially assumed office as a result of either an actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the Board (a "Proxy Contest") including by reason of any agreement intended to avoid or settle any Proxy Contest; or

3) The consummation of:

   a) A merger, consolidation or reorganization involving the Company, unless such merger, consolidation or reorganization is a "Non-Control Transaction." A "Non-Control Transaction" shall mean a merger, consolidation or reorganization of the Company where:

      i) the stockholders of the Company, immediately before such merger, consolidation or reorganization, own directly or indirectly immediately following such merger, consolidation or reorganization, at least seventy-five percent (75%) of the combined voting power of the outstanding Voting Securities of the corporation resulting from such merger or consolidation or reorganization (the "Surviving Corporation") in substantially the same proportion as their ownership of the Voting Securities immediately before such merger, consolidation or reorganization;

      ii) the individuals who were members of the Incumbent Board immediately prior to the execution of the agreement providing for such merger, consolidation or reorganization constitute at least two-thirds of the members of the board of directors of the Surviving

Corporation, or a corporation beneficially directly or indirectly owning a majority of the Voting Securities of the Surviving Corporation, and no agreement, plan or arrangement is in place to change the composition of the board of directors following the merger, consolidation or reorganization; and

iii) no Person other than (i) the Company, (ii) any Subsidiary, (iii) any employee benefit plan (or any trust forming a part thereof) maintained by the Company, the Surviving Corporation, or any Subsidiary, or (iv) any Person who, immediately prior to such merger, consolidation or reorganization had Beneficial Ownership of twenty percent (20%) or more of the then outstanding Voting Securities, has Beneficial Ownership of twenty percent (20%) or more of the combined voting power of the Surviving Corporation's then outstanding voting securities.

b) A complete liquidation or dissolution of the Company; or

c) The sale or other disposition of all or substantially all of the assets of the Company to any Person (other than a transfer to a Subsidiary).

Notwithstanding the foregoing, a Change in Control shall not be deemed to occur solely because any Person (the "Subject Person") acquired Beneficial Ownership of more than the permitted amount of the then outstanding Voting Securities as a result of the acquisition of Voting Securities by the Company which, by reducing the number of Voting Securities then outstanding, increases the proportional number of Shares Beneficially Owned by the Subject Persons, provided that if a Change in Control would occur (but for the operation of this sentence) as a result of the acquisition of Voting Securities by the Company, and after such share acquisition by the Company, the Subject Person becomes the Beneficial Owner of any additional Voting Securities which increases the percentage of the then outstanding Voting Securities Beneficially Owned by the Subject Person, then a Change in Control shall occur.

It is the intent of the Company that, with respect to any amount payable or benefit to be provided under this Policy that is subject to, and not exempt from Section 409A, the definition of "Change in Control" satisfies, and be interpreted in a manner that satisfies, the applicable requirements of Section 409A. If the definition of "Change in Control" would otherwise frustrate or conflict with the intent expressed above, that definition to the extent possible shall be interpreted and deemed amended so as to avoid such conflict.

Exhibit B

Restrictive Covenants

Confidential Information and Trade Secrets

The Executive recognizes that the Executive's position with the Company requires considerable responsibility and trust, and, in reliance on the Executive's loyalty, the Company may entrust the Executive with highly sensitive confidential, restricted and proprietary information involving Trade Secrets and Confidential Information.

"Trade Secret" shall be defined as any scientific or technical information, design, process, procedure, formula or improvement that is valuable and not generally known to competitors of the Company. "Confidential Information" is any data or information, other than Trade Secrets, that is important, competitively sensitive, and not generally known by the public, including, but not limited to, the Company's business plans, business prospects, training manuals, product development plans, bidding and pricing procedures, market strategies, internal performance statistics, financial data, confidential personnel information concerning employees of the Company, supplier data, operational or administrative plans, policy manuals, and terms and conditions of contracts and agreements. The terms "Trade Secrets" and "Confidential Information" shall not apply to information which is (i) already in the Executive's possession (unless such information was used in connection with formulating the Company's business plans, obtained by the Executive from the Company or was obtained by the Executive in the course of the Executive's employment by the Company), or (ii) required to be disclosed by any applicable law.

Except as may be required by law or legal process or an order of a court of competent jurisdiction, the Executive will not use or disclose any Trade Secrets or Confidential Information of the Company at any time after termination of employment and prior to such time as they cease to be Trade Secrets or Confidential Information through no act of the Executive in violation of this Section.

Executive will surrender to the Company all memoranda, notes, records, plans, manuals or other documents pertaining to the Company's business or the Executive's employment (including all copies thereof). The Executive will also leave with the Company all materials involving Trade Secrets or Confidential Information of the Company. All such information and materials, whether or not made or developed by the Executive, shall be the sole and exclusive property of the Company, and the Executive hereby assigns to the Company all of the Executive's right, title and interest in and to any and all of such information and materials.

Agreement Not to Compete and Agreement Not to Solicit

The Executive hereby covenants and agrees that during the Severance Period the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not participate in any business which competes with the Company including, without limitation, health maintenance organizations, insurance companies or prepaid health plan businesses in which the Company has been actively engaged during any part of the two (2) year period immediately preceding the Executive's employment Termination Date ("Company

Business"), in any Geographic Area (as defined below) in which the Company and/or any of its Affiliates is then doing business. For purposes of this Policy, "Geographic Area" means any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

The Executive hereby covenants and agrees that during the Severance Period, the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not: (1) interfere with the relationship of the Company and any of its employees, agents, representatives, consultants or advisors; (2) divert, or attempt to cause the diversion from the Company, any Company Business, nor interfere with relationships of the Company with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers; or (3) solicit, recruit or otherwise induce or influence any employee of the Company to accept employment in any business which competes with the Company Business, in any Geographic Area in which the Company and/or any of its Affiliates is then doing business.

Exhibit 10(f)

HUMANA INC.

EXECUTIVE SEVERANCE POLICY

This Humana Inc. Executive Severance Policy has been adopted by the Organization & Compensation Committee (the "Committee") of the Board of Directors of the Company to apply to selected executive employees of the Company. Executives will be eligible for coverage under the Policy for the payment of severance benefits upon termination of employment under certain circumstances, subject to the conditions set forth below. This Policy shall be effective as of the Effective Date as provided herein.

1. Definitions. For purposes of this Policy, the following terms shall have the following meaning:

"Annual Base Salary" shall mean an Executive's stated annual compensation without regard to any bonus, perquisite or other benefits.

"Annual Bonus" means the annual bonus or incentive compensation payable to Executive under the Company's annual bonus or incentive compensation program in which Executive participates from time to time.

"Cause" means (i) a felony conviction of Executive, (ii) the failure of Executive to contest prosecution for a felony, or (iii) Executive's willful misconduct or dishonesty, any of which is determined by the Compensation Committee to be directly and materially harmful to the business or reputation of the Company or any of its subsidiaries.

"CEO" shall mean the Company's President and Chief Executive Officer.

" CEO Direct Reports" shall mean Executive Officers of the Company who are direct reports to the Company's President and Chief Executive Officer.

"Company" means Humana Inc., a Delaware corporation.

"Code" means the Internal Revenue Code of 1986, as amended.

"Compensation Committee" means the Organization and Compensation Committee of the Board of Directors of the Company.

"Date of Termination" means the effective date of the relevant Executive's termination of employment with the Company.

"Effective Date" means March 1, 2019, or such later date as determined by the Compensation Committee with respect to an Executive.

"Executive" means Executive Officers of the Company (including the CEO) and such other individuals as identified by the Compensation Committee, in each case employed by

the Company or an affiliate of the Company on a full-time or part-time basis. Individuals will continue to be deemed an "Executive" eligible for the rights and benefits under this Policy for a period of twelve (12) months following a change in role or title at the Company that would otherwise have caused the individual to cease to be an eligible Executive Officer or other individual identified by the Compensation Committee as eligible.

"Executive Officer" shall include those executive officers designated by the Board under Rule 16a-1(f) under the Securities Exchange Act of 1934, as amended.

"Policy" means this Humana Inc. Executive Severance Policy.

"Separation from Service" means a termination of the employment relationship of the Executive with the Company or an affiliate within the meaning of Section 409A of the Code and Treasury Regulation section 1.409A-1(h) or any successor thereto.

"Severance Period" means (i) for the CEO, twenty-four (24) months following the Date of Termination, (ii) for CEO Direct Reports, eighteen (18) months following the Date of Termination and (iii) for all other Executives, six (6) months plus two (2) weeks per year of completed service.

"Severance Rate" means (i) for the CEO, the CEO's then current Annual Base Salary plus the target annual bonus or incentive compensation which could have been earned by the CEO, calculated as if all relevant goals had been met during the Company's then-current fiscal year pursuant to the terms of the incentive compensation plan in which the CEO participates, and (ii) for all of Executives, such Executive's then current Annual Base Salary.

2. Term of Policy. The term of this Policy shall begin on the Effective Date and shall continue in effect until modified or terminated by the Company pursuant to Section 13 hereof.

3. Termination. The Company may terminate the employment of Executive for any reason and at any time. In the event that the Company terminates the employment of Executive without Cause, Executive shall be entitled to the following rights and benefits under this Section 3:

3.1 Severance Benefits. Subject to Executive's compliance with all terms of this Policy, including, without limitation, Sections 5 and 6 hereof:

(i) Salary Continuation Payments. The Company will pay Executive salary continuation through the Severance Period at an annual rate equal to such Executive's Severance Rate; provided that any payments that would otherwise be paid during the Severance Period that remain outstanding as of March 15 of the year following the year during which the Date of Termination occurred shall be paid in a lump sum on such date. Salary continuation under this Section 3.1 shall be paid on a bi-weekly basis in accordance with the Company's customary payroll practices with the first payment to be made in accordance with Section 5 hereof, subject to the accelerated payment of the remaining amounts in accordance with the prior sentence.

(ii) Pro-Rata Bonus. The Company will pay Executive an amount equal to the product of (A) the Annual Bonus, if any, that Executive would have earned for the calendar year in which the Date of Termination occurs, based on achievement of the applicable performance

goals for each such calendar year, as uniformly applied to other Executives who remain employed through the end of the applicable performance period and (B) a fraction, the numerator of which is the number of days Executive was employed by the Company during the calendar year of termination, and the denominator of which is the number of days in such calendar year. This amount shall be paid on the date that Annual Bonuses are normally paid, but in no event later than March 15th of the year following the year in which the Date of Termination occurs.

(iii) Continued Health Benefit Coverage. The Company will provide to each Executive and Executive's eligible dependents, through the end of the (i) applicable Severance Period for such Executive, or (ii) the effective date of Executive's coverage under equivalent benefits from a new employer (provided that no such equivalent benefits shall be considered effective unless and until all pre-existing condition limitations and waiting period restrictions have been waived or have otherwise lapsed), at the Compensation Committee's option, either (A) continued medical and dental coverage under the Company's health care plan at the same level of coverage to which such Executive was entitled on the Date of Termination, subject to eligibility requirements and other conditions contained in the plan, including the requirement that Executive continue to pay the "employee portion" of the cost thereof, or (B) equivalent benefits (or equivalent cash value, payable on an after-tax basis), as determined in the sole reasonable discretion of the Compensation Committee. The coverage provided pursuant to this Section 3.1(iii) shall be in satisfaction of the Company's obligation to provide coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

(iv) Outplacement Services; Financial Planning. The Company will provide an Executive who is the CEO or a CEO Direct Report or otherwise designated by the Committee (i) with financial planning services during the one year period immediately following the Date of Termination on the same terms as the financial planning services were provided to such Executive immediately prior to the Date of Termination, and (ii) with outplacement services through an outplacement firm of the Company's choosing at a level of services to be determined by the Company, with such services to extend until the earlier of (A) one year following the Date of Termination or (B) the date Executive secures full time employment.

3.2 Accrued Rights. Within fifteen (15) business days following the Date of Termination, the Company will pay or provide Executive with (i) all accrued but unpaid base salary through the Date of Termination, (ii) vacation pay accrued but not used in accordance with the Company's vacation pay policy, (iii) any previously awarded but unpaid Annual Bonus for a completed calendar year prior to the Date of Termination, (iv) any unreimbursed business expenses that are reimbursable under the Company's business expense policy, and (v) all rights and benefits under the employee benefit plans of the Company in which Executive is then participating, (collectively, the "Accrued Rights").

3.3 No Additional Rights. Except as provided in this Section 3, Executive's participation under any benefit plan, program, policy or arrangement sponsored or maintained by the Company shall be treated in accordance with the terms of the applicable plan. Without limiting the generality of the foregoing, Executive's eligibility for and active participation in any of the retirement plans maintained by the Company will end on the Date of Termination and Executive will earn no additional benefits, including, without limitation, any additional service credit, under those plans after that date. Executive shall be treated as a terminated employee for purposes of all

such benefit plans and programs effective as of the Date of Termination, and shall receive all payments and benefits due under such plans and programs in accordance with the terms and conditions thereof.

4. Other Terminations. The Company may terminate the employment of Executive for any reason and at any time. In the event that the Company terminates the employment of Executive during the term of the Policy, other than a termination of employment by the Company for Cause, the Company will pay or provide Executive with all Accrued Rights. Executive may terminate his or her employment for any reason and at any time and shall not be entitled to any payments or benefits under this Policy by reason of such termination of employment from the Company. This Policy shall have no effect on the rights and benefits to which an Executive is entitled upon retirement under (without limitation) any retirement or savings plan of the Company, which shall be governed exclusively by the terms of such plans and agreements, as applicable.

5. Release.

5.1 As a condition precedent to receiving the payments and benefits as provided herein, Executive will execute (and not revoke) a general release of claims (the "Release"), in a form provided by the Company. If Executive fails to execute and deliver the Release, or revokes the Release, Executive agrees that he shall not be entitled to receive the payments and benefits described herein. For purposes of this Policy, the Release shall be considered to have been executed by Executive if it is signed by Executive's legal representative in the case of legal incompetence or on behalf of Executive's estate in the case of Executive's death.

5.2 Except as otherwise specified or agreed to by Executive and the Company, payment of any amounts described hereunder that are subject to the Release will begin on the 60th day following the Date of Termination, with the first such payment to include any amounts attributable to payroll intervals occurring prior to such date, provided, however, that, to the extent that the payments are exempt from Section 409A of the Code, such exempt payments shall be made beginning with the first payroll date following the effectiveness of the Release.

6. Restrictive Covenants. In consideration of Executive's employment by the Company and the rights and benefits of Executive provided by this Policy, Executive will enter into agreements that contain certain covenants regarding non-competition, non-solicitation, non-disparagement and specific enforcement with the restricted period for the non-competition and non-solicitation covenants to be the applicable Severance Period for such Executive, commencing upon the Date of Termination, with such covenants to be substantially in the form attached as Exhibit A hereto and effective as of the Effective Date hereof (the "Restrictive Covenants Effective Date").

7. Section 409A.

7.1 Compliance. It is intended that this Policy be exempt from the provisions of Section 409A of the Code and this Policy shall be construed, administered, and governed in a manner consistent with this intent. If and to the extent that any payment or benefit under this Policy is determined by the Company to constitute "non-qualified deferred compensation" subject to Section 409A of the Code and is payable to Executive by reason of Executive's termination of

employment, then such payment or benefit shall be made or provided to Executive only upon a Separation from Service as defined for purposes of Section 409A of the Code. Each severance payment under this Policy will be considered a "separate payment" and not one of a series of payments for purposes of Section 409A of the Code. To the extent that any benefits to be provided to Executive pursuant to this Policy are considered nonqualified deferred compensation and are reimbursements subject to Treasury Regulation Section 1.409A-3(i)(1)(iv), then (i) the reimbursement of eligible expenses related to such benefits shall be made on or before the last day of the Executive's taxable year following the Executive's taxable year in which the expense was incurred and (ii) notwithstanding anything to the contrary in this Policy or any plan providing for such benefits, the amount of expenses eligible for reimbursement during any taxable year of the Executive shall not affect the expenses eligible for reimbursement in any other taxable year. Nothing in this Policy will provide a basis for any person to take action against the Company or its affiliates based on matters covered by Section 409A of the Code and in no event will the Company or its affiliates be liable for any additional tax, interest or penalties that may be imposed on Executive under Section 409A of the Code or any damages for failing to comply with Section 409A of the Code.

7.2 Six Month Delay for Specified Executives. To the extent that any amount payable or benefit to be provided under this Policy constitutes a nonexempt "nonqualified deferred compensation plan" (as defined in Section 409A of the Code) upon a Separation from Service, and to the extent an Executive is deemed to be a "specified employee" (as that term is defined in Section 409A of the Code and pursuant to procedures established by the Company) on the Date of Termination, notwithstanding any other provision in this Policy to the contrary, such payment or benefit provision will not be made to the Executive during the six month period immediately following the Date of Termination. Instead, on the first day of the seventh month following the Date of Termination, all amounts that otherwise would have been paid or provided to the Executive during the six month period, but were not paid or provided because of this Section 7.2, will be paid or provided to the Executive at such time without interest. This six month delay will cease to be applicable if the Executive incurs a Separation from Service due to death or if the Executive dies before the six month period has expired.

8. Withholding Taxes. All compensation payable pursuant to this Policy shall be subject to reduction by all applicable withholding, social security and other federal, state and local taxes and deductions, and the Company shall be authorized to make all such withholdings to the extent it determines necessary under applicable law.

9. Acknowledgment. Executive acknowledges that this Policy does not constitute a contract of employment or impose on the Company any obligation to retain Executive as an employee and that this Policy does not prevent Executive from terminating employment at any time.

10. Non-Duplication of Benefits; CIC Policy. The severance benefit under this Policy is not intended to duplicate any other benefits provided by the Company in connection with the termination of an employee's employment, such as wage replacement benefits, pay-in-lieu-of-notice, severance pay, or similar benefits under any other benefit plans, severance programs, employment contracts, or applicable federal or state laws, such as the WARN Acts. Should such other benefits be payable, the severance benefit under this Policy will be reduced accordingly or,

alternatively, severance benefits previously paid under this Policy will be treated as having been paid to satisfy such other benefit obligations. In either case, the Company will determine how to apply this provision and may override other provisions in this Policy in doing so. In addition, and notwithstanding anything else provided herein, to the extent Executive is entitled to severance payments and benefits upon termination of employment pursuant to the Company's Change in Control Policy or any other change in control arrangements, this Policy will cease to apply and Executive's entitlement to severance benefits shall be governed solely by the Change in Control Policy.

11. Administration. The Compensation Committee is responsible for the administration of this Policy and shall have all powers and duties necessary to fulfill its responsibilities. The Compensation Committee shall determine any and all questions of fact, resolve all questions of interpretation of the Policy which may arise, and exercise all other powers and discretion necessary to be exercised under the terms of the Policy which it is herein given or for which no contrary provision is made. The Compensation Committee shall have full power and discretion to interpret the Policy and related documents, to resolve ambiguities, inconsistencies and omissions, to determine any question of fact, and to determine the rights and benefits, if any, of any Executive or other employee, in accordance with the provisions of the Policy. The Compensation Committee's decision with respect to any matter shall be final and binding on all parties concerned. The validity of any such interpretation, construction, decision, or finding of fact shall not be given de novo review if challenged in court, by arbitration, or in any other forum, and shall be upheld unless clearly arbitrary or capricious. The Compensation Committee may, from time to time, by action of its appropriate officers, delegate to designated persons or entities the right to exercise any of its powers or the obligation to carry out its duties under the Policy.

12. Amendment and Termination. The Company reserves the right to amend or terminate this Policy at any time and in any manner, without consent or advance notice to Executives or other employees. No amendment or termination of the Policy shall affect the rights of an Executive whose Date of Termination has occurred prior to the date of such amendment or termination of the Policy and who remains entitled to severance payments or benefits under this Policy.

Exhibit A

Restrictive Covenants

Confidential Information and Trade Secrets

The Executive recognizes that the Executive's position with the Company requires considerable responsibility and trust, and, in reliance on the Executive's loyalty, the Company may entrust the Executive with highly sensitive confidential, restricted and proprietary information involving Trade Secrets and Confidential Information.

"Trade Secret" shall be defined as any scientific or technical information, design, process, procedure, formula or improvement that is valuable and not generally known to competitors of the Company. "Confidential Information" is any data or information, other than Trade Secrets, that is important, competitively sensitive, and not generally known by the public, including, but not limited to, the Company's business plans, business prospects, training manuals, product development plans, bidding and pricing procedures, market strategies, internal performance statistics, financial data, confidential personnel information concerning employees of the Company, supplier data, operational or administrative plans, policy manuals, and terms and conditions of contracts and agreements. The terms "Trade Secrets" and "Confidential Information" shall not apply to information which is (i) already in the Executive's possession (unless such information was used in connection with formulating the Company's business plans, obtained by the Executive from the Company or was obtained by the Executive in the course of the Executive's employment by the Company), or (ii) required to be disclosed by any applicable law.

Except as may be required by law or legal process or an order of a court of competent jurisdiction, the Executive will not use or disclose any Trade Secrets or Confidential Information of the Company at any time after termination of employment and prior to such time as they cease to be Trade Secrets or Confidential Information through no act of the Executive in violation of this Section.

Upon termination of employment, Executive will surrender to the Company all memoranda, notes, records, plans, manuals or other documents pertaining to the Company's business or the Executive's employment (including all copies thereof). The Executive will also leave with the Company all materials involving Trade Secrets or Confidential Information of the Company. All such information and materials, whether or not made or developed by the Executive, shall be the sole and exclusive property of the Company, and the Executive hereby assigns to the Company all of the Executive's right, title and interest in and to any and all of such information and materials.

Agreement Not to Compete and Agreement Not to Solicit

The Executive hereby covenants and agrees that, for a period commencing on the Restrictive Covenants Effective Date and ending at the conclusion of the applicable Severance Period (as defined in the Humana Inc. Executive Severance Policy (the "Policy")), the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not participate in any business which competes with the Company including, without limitation, health maintenance organizations, insurance companies or prepaid health plan businesses in which the

Company has been actively engaged during any part of the two (2) year period immediately preceding the Date of Termination (as defined in the Policy) ("Company Business"), in any Geographic Area (as defined below) in which the Company and/or any of its Affiliates is then doing business. For purposes of this Policy, "Geographic Area" means any state, commonwealth or territory of the United States or any equivalent entity in any foreign country.

The Executive hereby covenants and agrees that, for a period commencing on the Restrictive Covenants Effective Date and ending at the conclusion of the applicable Severance Period, the Executive, directly or indirectly, personally, or as an employee, officer, director, partner, member, owner, stockholder, investor or principal of, or consultant or independent contractor with, another entity, shall not: (1) interfere with the relationship of the Company and any of its employees, agents, representatives, consultants or advisors; (2) divert, or attempt to cause the diversion from the Company, any Company Business, nor interfere with relationships of the Company with its policyholders, agents, brokers, dealers, distributors, marketers, sources of supply or customers; or (3) solicit, recruit or otherwise induce or influence any employee of the Company to accept employment in any business which competes with the Company Business, in any Geographic Area in which the Company and/or any of its Affiliates is then doing business.

Exhibit 10(ff)

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Restricted Stock Units. Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I.E. In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("**DERs**"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. Vesting of Restricted Stock Units. The Restricted Stock Units shall vest in three equal installments, with the first installment vesting on [December 15] of the year in which the Date of Grant occurs, and the next two installments vesting on [December 15] of each of the next two years (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a

Vesting Date, as applicable, a "**Vesting Period**") subject to Grantee's continued employment with the Company through each such Vesting Date; provided, that, notwithstanding the foregoing, upon certain terminations (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest as follows:

1. Upon a termination of Grantee's employment with the Company due to Grantee's death or Disability, all of the unvested Restricted Stock Units and DERs will immediately vest;

2. In the event of a Change in Control Termination, all of the unvested Restricted Stock Units and DERs will immediately vest;

3. Upon the termination of Grantee's employment due to Retirement, a prorated portion of the Restricted Stock Units (and related DERs) that would have vested on the next scheduled Vesting Date shall vest on the next scheduled Vesting Date, with the proration to be determined by calculating the product of (i) the quotient of (x) the number of completed months Grantee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current restricted Vesting Period, multiplied by (ii) the total number of Restricted Stock Units that were scheduled to vest on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant;

4. [In the event that Grantee's employment with the Company terminates due to a Divestiture of the business to which Grantee provides services and (i) the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion, all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Dates in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Dates; provided that the Grantee must remain employed by the divested business on each of the applicable Vesting Dates. For the avoidance of doubt, if the Grantee's employment with the aforementioned divested business terminates before a Vesting Date, the Grantee's unvested Restricted Stock Units will no longer vest pursuant to this Section I.C.4 and will be forfeited upon such termination; or (ii) the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, the portion of the unvested Restricted Stock Units (and related DERs) that would ordinarily vest within twelve (12) months of the termination of employment due to a Divestiture shall continue to vest and become vested on regular Vesting Date(s) as if Grantee had remained employed by the Company through such dates][1];

5. [In the event that Grantee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, the portion of the unvested Restricted Stock Units (and related DERs) that would ordinarily vest within twelve (12) months of the termination of employment due to a Workforce Reduction or a Position Elimination shall continue to vest and become vested on regular Vesting Date(s) as if Grantee had remained employed by the Company through such Vesting Dates; and][2]

[1] NTD: Applicable for annual awards. Remove for new hires.
[2] NTD: Applicable for annual awards. Remove for new hires.

6. In the event that Grantee's employment with the Company terminates due to a transfer to a Strategic Joint Venture, [due to a Divestiture of the business to which Grantee provides services, or due to a Workforce Reduction or a Position Elimination,][3] all outstanding Restricted Stock Units (and related DERs) shall continue to vest on the regular Vesting Date(s) in the same manner as if Grantee continued to be employed by the Company through the applicable Vesting Date(s)[; provided that, in the case of a termination due to a Divestiture of the business, if the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion, the Grantee must remain employed by the divested business on each of the applicable Vesting Dates. For the avoidance of doubt, if the Grantee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Grantee's unvested Restricted Stock Units will no longer vest pursuant to this Section I.C.6 and will be forfeited upon such termination.][4]

D. Forfeiture. Except as set forth in Section I.C, upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

E. Distributions. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination, then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. Taxes. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the

[3] NTD: Applicable for new hires. Remove for annual awards.
[4] NTD: Applicable for new hires. Remove for annual awards.

Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.** Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.** Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform the same or similar responsibilities Grantee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Grantee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Grantee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. **Agreement Not to Solicit Protected Relationships.** During the Restricted Period and in connection with a Competitive Product or Service, Grantee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Grantee worked, had business contact, or about whom Grantee gained non-public or confidential information ("Employees or Former Employees"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II.A, II.B and II.C. shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the acceleration or continuation of the vesting of the Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited, with such value measured by multiplying the number of Shares underlying the Restricted Stock Units that vested as a result of the termination of employment by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II.B and II. C above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D, in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Grantee's employment termination date with the Company or its successor, to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II.E shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II.B. and II C. shall remain in full force and effect.

F. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. Injunctive Relief; Invalidity of Any Provision. Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and

as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. No Employment Agreement. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in

Control, if the employment of Grantee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked or for which Grantee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Grantee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Grantee, the relocation of Grantee's office at which Grantee is to perform his or her duties to a location more than thirty (30) miles from the location at which Grantee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Grantee's last day of employment with the Company regardless of the reason for Grantee's separation.

(vii) "**Position Elimination**" means the elimination of Grantee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Grantee, directly or indirectly (e.g., through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(ix) "**Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Grantee's employment with the Company and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

Exhibit 10(gg)

HUMANA INC.
RESTRICTED STOCK UNIT AGREEMENT WITH PERFORMANCE VESTING
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS RESTRICTED STOCK UNIT AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Grantee"**).

WITNESSETH:

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**) was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to award to Grantee Restricted Stock Units in accordance with the Plan.

NOW, THEREFORE, in consideration of the award of Restricted Stock Units to Grantee, the promises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Grantee agree as follows:

I. RESTRICTED STOCK UNIT GRANT

A. Grant. Subject to the terms and conditions hereinafter set forth, and in accordance with the provisions of the Plan, the Company hereby grants to Grantee, and Grantee hereby accepts from the Company <shares_awarded> Performance-Based Restricted Stock Units (the "**Restricted Stock Units**") (which represents the target amount of shares available as set out on Appendix A). Each Restricted Stock Unit represents the right of Grantee to receive (i) one (1) Share on the date of distribution provided for in Section I.E. In addition, Grantee shall also have the right to receive all of the cash or in-kind dividends that are paid with respect to the Shares represented by the Restricted Stock Units to which this award relates ("**DERs**"). Dividend equivalents with respect to any such Share shall be paid on the same date that such Share is issued to Grantee pursuant to Section I.E. hereof. The DERs shall be subject to the same terms and conditions applicable to the Restricted Stock Units, including, without limitation, the restrictions and non-transferability, vesting, forfeiture and distribution provisions contained in Sections I.B through I.E., inclusive, of this Agreement. In the event that the Restricted Stock Units are forfeited pursuant to Section I.D. hereof, the related DER shall also be forfeited.

B. Restrictions and Non-Transferability. The Restricted Stock Units and DERs may not be sold, transferred, pledged, assigned or otherwise alienated or hypothecated. In addition, such Restricted Stock Units and DERs shall be subject to forfeiture in accordance with the provisions of Section I.D.

C. Vesting of Shares. Subject to the terms set forth below, if as of the third anniversary of the Date of Grant (the "**Vesting Date**" and the period between the Date of Grant and the Vesting Date, a "**Vesting Period**"), Grantee and the Company have achieved the performance goals to be set forth in

Appendix A, the Restricted Stock Units and related DERs shall vest to the extent such performance goals have been achieved. Effective on the Vesting Date, any portion of the Restricted Stock Units and the related DERs for which the performance goals set forth in Appendix A have not been satisfied shall be immediately forfeited; provided, however, notwithstanding the foregoing, upon certain terminations of employment (as set forth below), all or a portion of the unvested Restricted Stock Units and DERs will vest as follows:

1. Upon a termination of Grantee's employment with the Company due to Grantee's death or Disability, all of the unvested Restricted Stock Units and DERs will immediately vest at target level;

2. In the event of a Change in Control Termination, all of the unvested Restricted Stock Units and DERs will immediately vest at target levels;

3. Upon the termination of Grantee's employment due to Retirement, [Position Elimination, Workforce Reduction][1] or a Divestiture of the business to which Grantee provides services if the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, a prorated portion of the Restricted Stock Units (and related DERs) that would have vested on the next scheduled Vesting Date shall vest on the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months Grantee has been employed since the Date of Grant, divided by (y) the number of months in the current restricted Vesting Period, multiplied by (B) the total number of Restricted Stock Units that would have vested on the next scheduled Vesting Date (taking into account achievement of applicable performance goals). For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant; or

5. Upon the termination of Grantee's employment due to [Position Elimination, Workforce Reduction][2] or a Divestiture of the business to which Grantee provides services if the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion, or due to a transfer to a Strategic Joint Venture, Grantee shall continue to vest in the Restricted Stock Units (and related DERs) as if Grantee remained employed through the applicable Vesting Date (taking into account achievement of applicable performance goals); provided that, in the case of a termination due to a Divestiture of the business, the Grantee must remain employed by the divested business on the applicable Vesting Dates. For the avoidance of doubt, if the Grantee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Grantee's unvested Restricted Stock Units will no longer vest pursuant to this Section I.C.5 and will be forfeited upon such termination.

D. Forfeiture. Except as set forth in Section I.C, upon the termination of Grantee's employment with the Company prior to the time the Restricted Stock Units and DERs have vested, the Restricted Stock Units and DERs shall be forfeited immediately by Grantee.

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[1] NTD: Applicable for annual awards. Remove for new hires.
[2] NTD: Applicable for new hires. Remove for annual awards.

E. **Distributions**. The Company shall issue to Grantee (or, if applicable, Grantee's estate or personal representative) Shares (or such other securities or other property into which the Shares have been converted, with any partial Shares or other securities to be settled in cash) with respect to Grantee's Restricted Stock Units and dividend equivalents accrued pursuant to the DERs with respect to such Restricted Stock Units, within 30 days of the date that the Restricted Stock Units vest in accordance with Section I.C hereof; provided, however, that, to the extent that the Restricted Stock Units are considered deferred compensation subject to Section 409A of the Code and the Restricted Stock Units vest in connection with Grantee's Change in Control Termination (defined below), then unless the Change in Control is a Section 409A Change in Control, the distribution of Shares (or such other securities or other property into which the Shares have been converted) shall not be accelerated to the vesting date but such distribution shall instead occur based on the Vesting Dates set forth in Section I.C. hereof. A "Section 409A Change in Control" shall mean a Change in Control that also constitutes a "change in ownership or effective control" of the Company or a "change in ownership of a substantial portion of the assets of" the Company, in each case within the meaning of Section 409A of the Code. Notwithstanding anything to the contrary contained herein, no Shares may be transferred to any person other than Grantee unless such other person demonstrates to the reasonable satisfaction of the Company such person's right to the transfer.

F. **Taxes**. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company ("**Withholding Taxes**") in connection with the distribution of Shares, cash or other property or, to the extent applicable, vesting of the Restricted Stock Units or DERs hereunder, shall be paid by Grantee at such time. Notwithstanding the foregoing, the Company shall withhold delivery of a number of Shares with a Fair Market Value as of the distribution date equal to the Withholding Taxes required to be withheld in connection with such distribution.

II. AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.

Grantee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Grantee) that it is providing Grantee, and in the significant time, money, training, team building and other efforts it expends to develop Grantee's skills to assist in performing Grantee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Grantee agrees are valuable assets of the Company to which it has devoted substantial resources. Grantee acknowledges that the grant Grantee is receiving under the Plan is a meaningful way that the Company entrusts Grantee with its goodwill and aligns Grantee with the Company objective of increasing the value of the Company's business. Accordingly, Grantee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to

restrict Grantee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. Agreement Not to Compete. Grantee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Grantee will not, directly or indirectly, perform the same or similar responsibilities Grantee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Grantee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Grantee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Grantee that are satisfactory to the Company that Grantee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Grantee from investing Grantee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Grantee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. Agreement Not to Solicit Protected Relationships. During the Restricted Period and in connection with a Competitive Product or Service, Grantee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. Agreement Not to Solicit Employees. During the Restricted Period, Grantee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Grantee worked, had business contact, or about whom Grantee gained non-public or confidential information ("**Employees or Former Employees**"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Grantee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth in Sections II.A, II.B and II.C. shall remain in full force and effect.

2. In the event Grantee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Restricted Stock Unit, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Grantee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Grantee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Grantee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the Restricted Stock Units that would remain outstanding subject to the achievement of the performance goals (or the value of the acceleration, if any, of the vesting of any Restricted Stock Unit as a result of Grantee's termination under this Agreement or the Plan that would otherwise have been forfeited), with such value measured by multiplying the number of Shares underlying the Restricted Stock Units. assuming target performance has been achieved (or by the number of Shares underlying the Restricted Stock Unit that become vested as a result of the acceleration of vesting, if any). by the per Share Fair Market Value on the Last Day, divided by (B) Grantee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Grantee, in its discretion.

3. In the event Grantee is discharged by the Company other than with Cause prior to vesting herein of the Restricted Stock Units, the prohibitions set forth in Sections II.B and II. C above shall remain in full force and effect.

4. After the vesting of the Restricted Stock Unit, the prohibitions on Grantee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D, in the event of a Change in Control Termination, the prohibitions on Grantee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Grantee's employment termination date with the Company or its successor, to Grantee the Non-Compete Payment. Notwithstanding any previous agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Grantee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Grantee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section

II.E shall supersede any agreement between Grantee and the Company relating to the prohibitions on Grantee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Grantee and the Company, (ii) any agreement between Grantee and the Company not related to the employment of Grantee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Grantee set forth in Sections II.B. and II.C. shall remain in full force and effect.

F. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. **Injunctive Relief; Invalidity of Any Provision**. Grantee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Grantee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Grantee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Grantee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. **Binding Effect & Adjustment.** This Agreement shall be binding and conclusive upon each successor and assign of the Company. Grantee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Shares during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Grantee and all rights granted to Grantee and to the Company shall be binding upon Grantee's heirs and legal representatives.

B. **Amendment**. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. **Governing Law.** Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. **No Employment Agreement**. Nothing herein confers on Grantee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Grantee's employment or other service at any time.

E. **Severability.** If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

F. **Defined Terms.**

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Grantee and any person or persons claiming through Grantee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event unvested Restricted Stock Units and DERs are assumed, converted, continued or substituted in connection with a Change in Control, if the employment of Grantee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Grantee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Grantee worked or for which Grantee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Grantee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Grantee, the relocation of Grantee's office at which Grantee is to perform his or her duties to a location more than thirty (30) miles from the location at which Grantee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Grantee's last day of employment with the Company regardless of the reason for Grantee's separation.

(vii) "**Position Elimination**" means the elimination of Grantee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Grantee, directly or indirectly (e.g., through employees whom Grantee supervised) had material business contact and/or about whom Grantee obtained confidential information and trade secrets.

(ix) **"Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Grantee provided material services on behalf of the Company (or in which Grantee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Grantee's employment with the Company and a period of twelve (12) months after the Last Day. Grantee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

G. Execution. If Grantee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

H. Section 409A. All Restricted Stock Units granted pursuant to this Agreement are intended either to be exempt from Section 409A of the Code, or, if subject to Section 409A of the Code, to be administered, operated and construed in compliance with Section 409A of the Code and any guidance issued thereunder. This Agreement and the Plan shall be administered in a manner consistent with this

intent and any provision that would cause the Agreement or Plan to fail to satisfy the first sentence of this section shall have no force and effect. Notwithstanding anything contained herein to the contrary, Restricted Stock Units (and related DERs) that (a) constitute "nonqualified deferred compensation" as defined under Section 409A of the Code and (b) vest as a consequence of Grantee's termination of employment, shall not be delivered until the date that Grantee incurs a "separation from service" within the meaning of Section 409A of the Code (or, if Grantee is a "specified employee" within the meaning of Section 409A of the Code and any guidance issued thereunder, the date that is six months and one day following the date of such "separation from service" (or on the date of Grantee's death, if earlier)). In addition, each amount to be paid or benefit to be provided to Grantee pursuant to this Agreement that constitutes deferred compensation subject to Section 409A of the Code, shall be construed as a separate identified payment for purposes of Section 409A of the Code.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Grantee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Grantee"

_____
<first_name> <middle_name> <last_name>

APPENDIX A

Payout Matrix for Performance-Based Restricted Stock Units

The <shares_awarded> Restricted Stock Units represent the target number of shares of common stock that could potentially be earned on the Vesting Date if the below strategic measure is achieved at the target level. Performance above or below the target level will yield vesting of a different amount of shares of common stock, according to the following matrix:

Exhibit 10(hh)

HUMANA INC.
INCENTIVE STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, an Incentive Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of <award_price> per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date> (the "**Expiration Date**").

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a Vesting Date, as applicable, a "**Vesting Period**"), subject to Optionee's continued employment with the Company through each Vesting Date, except as set forth in Section D below.

D. Effect of Termination of Employment on Option. If the employment of Optionee is terminated for any reason, the Option shall vest and remain exercisable as follows, but in no event beyond the Expiration Date:

1. If the employment of Optionee is terminated by the Company for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately.

2. In the event of Optionee's Retirement, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such Retirement, this Option (or portion hereof) shall be exercisable

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at any time within two (2) years after the date of Retirement, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of Retirement, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such Retirement, a prorated portion of the Option that would have vested on the next scheduled Vesting Date shall vest and become exercisable upon the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months Optionee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current Vesting Period, multiplied by (B) the total number of Options that were scheduled to vest and become exercisable on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant. The portion of the Option that vests pursuant to clause (ii) of this Section I.D.2 shall be exercisable at any time within two (2) years following the date of Optionee's Retirement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement.

3. In the event of termination due to death or Disability of Optionee while in the employ of the Company, this Option shall become fully vested and exercisable of the termination due to death or Disability of Optionee and shall remain exercisable by Optionee or the person or the persons to whom those rights pass by will or by the laws of descent and distribution or, if appropriate, by the legal representative of Optionee or the estate of Optionee at any time within two (2) years after the date of such death or the date of determination of Disability, but in no event beyond the Expiration Date.

4. In the event that Optionee's employment with the Company terminates due to a Divestiture of the business to which Optionee provides services, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, [and (A) the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][1] the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that the Option would become fully vested; provided that[, in the event the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][2] the Optionee must remain employed by the divested business on each of the

[1] NTD: Applicable only for annual award. Remove for new hire.
[2] NTD: Applicable only for new hire. Remove for annual award.

applicable Vesting Dates. For the avoidance of doubt, if the Optionee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Optionee's unvested Option will no longer vest pursuant to this Section I.D.4 and will be forfeited upon such termination; [or (B) the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur during the twelve (12) month period immediately following the termination of Optionee's employment as if Optionee continued to be employed by the Company during such period,][3] and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.4. shall be immediately forfeited upon Optionee's termination of employment.

5. In the event that Optionee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable in accordance with this Section I.D.6, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur [during the twelve (12) month period immediately following the termination of Optionee's employment][4] as if Optionee continued to be employed by the Company, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.5. shall be immediately forfeited upon Optionee's termination of employment.

6. In the event that Optionee's employment with the Company terminates due to a transfer to a Strategic Joint Venture, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that

[3] NTD: Applicable only for annual award. Remove for new hire.
[4] NTD: Applicable for annual awards. Remove for new hires.

the Option would become fully vested as if Optionee continued to be employed through such Vesting Date, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.6. shall be immediately forfeited upon Optionee's termination of employment.

7. In the event of a Change in Control Termination, this Option (or any option or other award for which this Option is substituted or into which this Option is converted into in connection with the Change in Control) shall become fully vested and immediately exercisable in its entirety, and this Option (or any substitute or converted award) shall remain exercisable at any time within two (2) years after the date of termination of Optionee's employment, but in no event beyond the Expiration Date.

8. If the employment of Optionee terminates for any reason other than for Cause, Retirement, death or Disability, Position Elimination, Workforce Reduction, Divestiture, due to a transfer to a Strategic Joint Venture or as a result of a Change in Control Termination, unless otherwise specified herein, all the rights of Optionee under this Agreement then exercisable shall remain exercisable at any time within ninety (90) days after the later of the date of such termination and the last date that the Option vests pursuant to the terms of this Agreement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of the Optionee's termination of employment and could not become exercisable after taking into account the provision of Section I.D. shall be immediately forfeited upon Optionee's termination of employment.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows:

a) In full in cash upon the exercise of the Option;

b) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option; or

c) A combination of I.E.(2)(a) and I.E.(2)(b) above.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.** Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.** Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform the same or similar responsibilities Optionee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Optionee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Optionee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. **Agreement Not to Solicit Protected Relationships.** During the Restricted Period and in connection with a Competitive Product or Service, Optionee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. **Agreement Not to Solicit Employees.** During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Optionee worked, had business contact, or about whom Optionee gained non-public or

confidential information ("**Employees or Former Employees**"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Option, the prohibitions on Optionee set forth in Sections II.A, II.B and II.C shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Option, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the acceleration or continuation of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited, with such value measured by multiplying the number of Shares underlying the Options that vested as a result of the termination of employment by the difference of the per Share Fair Market Value on the Last Day minus the applicable per Share exercise price, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by Company other than with Cause prior to vesting herein of the Option, the prohibitions set forth in Sections II.B and II.C above shall remain in full force and effect.

4. After the vesting of the Option, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D., in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Optionee's employment termination date with the Company or its successor, to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II.E shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II.B. and II C. shall remain in full force and effect.

F. **Governing Law.** Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. **Injunctive Relief; Invalidity of Any Provision**. Optionee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Optionee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect. Any provision in this Agreement determined by competent authority to be in conflict with 422 of the Internal Revenue Code of 1986, as amended, or its successor, in regard to qualifying this Option as an incentive stock option shall be ineffective ab initio to the extent of such conflict.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign,

transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever, such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control, if the employment of Optionee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Optionee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Optionee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Optionee, the relocation of Optionee's office at which Optionee is to perform his or her duties to a location more than thirty (30) miles from the location at which Optionee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Optionee's last day of employment with the Company regardless of the reason for Optionee's separation.

(vii) "**Position Elimination**" means the elimination of Optionee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last Day, Optionee, directly or indirectly (e.g., through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(ix) "**Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Optionee's employment with the Company and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

I. **Execution.** If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

Exhibit 10(ii)

HUMANA INC.
STOCK OPTION AGREEMENT
AND AGREEMENT NOT TO COMPETE OR SOLICIT
UNDER THE 2011 STOCK INCENTIVE PLAN

THIS AGREEMENT (**"Agreement"**) made as of <award_date> (the "**Date of Grant**") by and between **HUMANA INC.**, a corporation duly organized and existing under the laws of the State of Delaware (hereinafter referred to as the **"Company"**), and <first_name> <middle_name> <last_name>, an employee of the Company (hereinafter referred to as **"Optionee"**).

WITNESSETH

WHEREAS, the Humana Inc. 2011 Stock Incentive Plan (the **"Plan"**), was approved by the Company's Board of Directors and stockholders; and

WHEREAS, the Company desires to grant to Optionee an option to purchase shares of common stock of the Company in accordance with the Plan;

NOW, THEREFORE, in consideration of the premises and mutual covenants hereinafter set forth, and other good and valuable consideration, the Company and Optionee agree as follows:

I. OPTION GRANT

A. Grant of Option. The Company hereby grants to Optionee, as a matter of separate inducement and agreement and not in lieu of salary or other compensation for services, a Non-Qualified Stock Option to purchase <shares_awarded> shares of the $.16-2/3 par value common stock of the Company (**"Common Stock"**) at the purchase price of <award_price> per share (the **"Option"**) exercisable on the terms and conditions set forth herein.

B. Term. The term of the Option shall commence upon the Date of Grant, and shall expire on <expire_Date> (the "**Expiration Date**").

C. Vesting of Option. Except as otherwise set forth herein, the Option shall be exercisable by Optionee or his/her personal representative on and after the first anniversary of the Date of Grant in cumulative annual installments of one-third of the number of Shares covered hereby (each such date, a "**Vesting Date**" and the period between each Vesting Date or between the Date of Grant and a Vesting Date, as applicable, a "**Vesting Period**"), subject to Optionee's continued employment with the Company through each Vesting Date, except as set forth in Section D below.

D. Effect of Termination of Employment on Option. If the employment of Optionee is terminated for any reason, the Option shall vest and remain exercisable as follows:

1. If the employment of Optionee is terminated by the Company for Cause, all the rights of Optionee under this Agreement, whether or not exercisable, shall terminate immediately.

2. In the event of Optionee's Retirement, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such Retirement, this Option (or portion hereof) shall be exercisable

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at any time within two (2) years after the date of Retirement, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of Retirement, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such Retirement, a prorated portion of the Option that would have vested on the next scheduled Vesting Date shall vest and become exercisable upon the next scheduled Vesting Date, with the proration to be determined by calculating the product of (A) the quotient of (x) the number of completed months Optionee has been employed since the Date of Grant or the most recent Vesting Date, as applicable, divided by (y) the number of months in the current Vesting Period, multiplied by (B) the total number of Options that were scheduled to vest and become exercisable on the next scheduled Vesting Date. For purposes of the foregoing calculation, a month is complete on the day in the following month that corresponds to the Date of Grant. The portion of the Option that vests pursuant to clause (ii) of this Section I.D.2 shall be exercisable at any time within two (2) years following the date of Optionee's Retirement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement. Any portion of the Option that is not exercisable on the date of Optionee's Retirement and could not become exercisable after taking into account the provisions of this Section I.D.2. shall be immediately forfeited upon Optionee's Retirement.

3. In the event of termination due to death or Disability of Optionee while in the employ of the Company, this Option shall become fully vested and exercisable of the termination due to death or Disability of Optionee and shall remain exercisable by Optionee or the person or the persons to whom those rights pass by will or by the laws of descent and distribution or, if appropriate, by the legal representative of Optionee or the estate of Optionee at any time within two (2) years after the date of such death or the date of determination of Disability, regardless of the Expiration Date.

4. In the event that Optionee's employment with the Company terminates due to a Divestiture of the business to which Optionee provides services, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, [and (A) the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][1] the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that the Option would become fully vested; provided that[, in the event the Company maintains a strategic interest in the divested business, as determined by the Committee in its sole discretion,][2] the Optionee must remain employed by the divested business on each of the

[1] NTD: Applicable only for annual award. Remove for new hire.
[2] NTD: Applicable only for new hire. Remove for annual award.

applicable Vesting Dates. For the avoidance of doubt, if the Optionee's employment with the aforementioned divested business terminates prior to a Vesting Date, the Optionee's unvested Option will no longer vest pursuant to this Section I.D.4 and will be forfeited upon such termination; [or (B) the Company does not maintain a strategic interest in the divested business, as determined by the Committee in its sole discretion, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur during the twelve (12) month period immediately following the termination of Optionee's employment as if Optionee continued to be employed by the Company during such period,][3] and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.4. shall be immediately forfeited upon Optionee's termination of employment.

5. In the event that Optionee's employment with the Company terminates due to a Workforce Reduction or a Position Elimination, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable in accordance with this Section I.D.6, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates that would occur [during the twelve (12) month period immediately following the termination of Optionee's employment][4] as if Optionee continued to be employed by the Company, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.5. shall be immediately forfeited upon Optionee's termination of employment.

6. In the event that Optionee's employment with the Company terminates due to a transfer to a Strategic Joint Venture, (i) to the extent that this Option (or portion hereof) is exercisable as of the date of such termination of employment, this Option (or portion hereof) shall be exercisable until the date that is ninety (90) days following the last date on which any portion of the Option is scheduled to vest, but in no event beyond the Expiration Date, and only to the extent the Option (or portion hereof) was exercisable at the date of such termination of employment, and (ii) to the extent that this Option (or portion hereof) is not exercisable as of the date of such termination of employment, the unvested portion of the Option shall continue to vest and become exercisable upon the regular Vesting Dates through the date that

[3] NTD: Applicable for annual awards. Remove for new hires.
[4] NTD: Applicable for annual awards. Remove for new hires.

the Option would become fully vested as if Optionee continued to be employed through such Vesting Date, and the portion of the Option that vests pursuant to this clause (ii) shall be exercisable for ninety (90) days following the last date on which any portion of the Option vests, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of Optionee's termination of employment and could not become exercisable after taking into account the provisions of this Section I.D.6. shall be immediately forfeited upon Optionee's termination of employment.

7. In the event of a Change in Control Termination, this Option (or any option or other award for which this Option is substituted or into which this Option is converted into in connection with the Change in Control) shall become fully vested and immediately exercisable in its entirety, and this Option (or any substitute or converted award) shall remain exercisable at any time within two (2) years after the date of termination of Optionee's employment, but in no event beyond the Expiration Date.

8. If the employment of Optionee terminates for any reason other than for Cause, Retirement, death or Disability, Position Elimination, Workforce Reduction, Divestiture, due to a transfer to a Strategic Joint Venture or as a result of a Change in Control Termination, unless otherwise specified herein, all the rights of Optionee under this Agreement then exercisable shall remain exercisable at any time within ninety (90) days after the later of the date of such termination and the last date that the Option vests pursuant to the terms of this Agreement, but in no event beyond the Expiration Date. Any portion of the Option that is not exercisable on the date of the Optionee's termination of employment and could not become exercisable after taking into account the provision of Section I.D. shall be immediately forfeited upon Optionee's termination of employment.

E. Exercise of Option.

1. The Option shall be exercisable only by written notice to the Secretary of the Company at the Company's principal executive offices, or through the online procedure to such broker-dealer as designated by the Company, Optionee or his/her legal representative as herein provided. Such notice shall state the number of Shares with respect to which the Option is being exercised and shall be signed, or authorized electronically, by Optionee or his/her legal representative, as applicable.

2. The purchase price shall be paid as follows:

a) In full in cash upon the exercise of the Option;

b) By tendering to the Company Shares owned by Optionee prior to the date of exercise and having an aggregate Fair Market Value equal to the cash exercise price applicable to the Option;

c) A combination of I.E.(2)(a) and I.E.(2)(b) above; or

(d) Through the cashless exercise provisions of the designated broker-dealer as described in the procedures communicated to Optionee by the Company.

3. Federal, state and local income and employment taxes and other amounts as may be required by law to be collected by the Company (**"Withholding Taxes"**) in connection with the exercise of the Option shall be paid pursuant to the Plan by Optionee prior to the delivery of any Common Stock under this Agreement. The Company shall, at Optionee's election, withhold delivery of a number of Shares

with a Fair Market Value as of the exercise date equal to the Withholding Taxes in satisfaction of Optionee's obligations hereunder.

II. **AGREEMENT NOT TO COMPETE AND AGREEMENT NOT TO SOLICIT.** Optionee agrees and understands that the Company's business is a profit-generating business operating in a highly competitive business environment and that the Company has a legitimate business interest in, among other things, its confidential information and trade secrets (including as protected in other agreements and policies between the Company and Optionee) that it is providing Optionee, and in the significant time, money, training, team building and other efforts it expends to develop Optionee's skills to assist in performing Optionee's duties for the Company, including with respect to establishing, developing and maintaining the goodwill and business relationships with Protected Relationships (defined below) and employees, each of which Optionee agrees are valuable assets of the Company to which it has devoted substantial resources. Optionee acknowledges that the grant Optionee is receiving under the Plan is a meaningful way that the Company entrusts Optionee with its goodwill and aligns Optionee with the Company objective of increasing the value of the Company's business. Accordingly, Optionee acknowledges the importance of protecting the value of the Company's business through, among other things, covenants to restrict Optionee from engaging in activities that would adversely affect the value of the Company and its goodwill.

A. **Agreement Not to Compete.** Optionee agrees that during the Restricted Period (defined below) and within the Restricted Geographic Area (defined below), Optionee will not, directly or indirectly, perform the same or similar responsibilities Optionee performed for the Company in connection with a Competitive Product or Service (defined below). Notwithstanding the foregoing, Optionee may accept employment with a Competitor (defined below) whose business is diversified, provided that: (1) Optionee will not be engaged in working on or providing Competitive Products or Services, or otherwise use or disclose the Company's confidential information or trade secrets; and (2) the Company receives written assurances from the Competitor and Optionee that are satisfactory to the Company that Optionee will not work on or provide Competitive Products or Services, or otherwise use or disclose confidential information or trade secrets. In addition, nothing in this Agreement is intended to prevent Optionee from investing Optionee's funds in securities of a person engaged in a business that is directly competitive with the Company if the securities of such a person are listed for trading on a registered securities exchange or actively traded in an over-the-counter market and Optionee's holdings represent less than one percent (1%) of the total number of outstanding shares or principal amount of the securities of such a person.

B. **Agreement Not to Solicit Protected Relationships.** During the Restricted Period and in connection with a Competitive Product or Service, Optionee shall not, individually or jointly with others, directly or indirectly: (1) solicit or attempt to solicit any Protected Relationships (defined below); or (2) induce or encourage any Protected Relationships to terminate a relationship with the Company or to otherwise cease to accept services or products from the Company.

C. **Agreement Not to Solicit Employees.** During the Restricted Period, Optionee shall not, individually or jointly with others, directly or indirectly: (1) or by assisting others, solicit, recruit, hire, or

encourage (or attempt to solicit, recruit, hire or encourage), any Company employees or former employees with whom Optionee worked, had business contact, or about whom Optionee gained non-public or confidential information ("**Employees or Former Employees**"); (2) contact or communicate with Employees or Former Employees for the purpose of inducing, assisting, encouraging and/or facilitating them to terminate their employment with the Company or find employment or work with another person or entity; (3) provide or pass along to any person or entity the name, contact and/or background information about any Employees or Former Employees or provide references or any other information about them; (4) provide or pass along to Employees or Former Employees any information regarding potential jobs or entities or persons to work for, including but not limited to job openings, job postings, or the names or contact information of individuals or companies hiring people or accepting job applications; and/or (5) offer employment or work to any Employees or Former Employees. For purposes of this covenant, "Former Employees" shall refer to employees who are not employed by the Company at the time of the attempted recruiting or hiring, but were employed by, or working for the Company in the three (3) months prior to the time of the attempted recruiting or hiring and/or interference.

D. Effect of Termination of Employment other than a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. In the event Optionee voluntarily resigns or is discharged by the Company with Cause at any time prior to the vesting of the Option, the prohibitions on Optionee set forth in Sections II.A, II.B and II.C shall remain in full force and effect.

2. In the event Optionee is discharged by the Company other than with Cause, including in connection with a Workforce Reduction or Position Elimination, or certain divestiture related terminations, prior to the vesting of the Option, the prohibitions set forth in Section II.A shall remain in full force and effect during the period of time following Optionee's termination equal to the lesser of (x) the Restricted Period or (y) the period of time during which Optionee is deemed to be entitled to severance measured by the sum of (i) the number of weeks Optionee is entitled to severance under the Company's applicable severance policy, plus (ii) a number of weeks equal to (A) the value of the acceleration or continuation of the vesting of any Options as a result of Optionee's termination under this Agreement or the Plan that would otherwise have been forfeited, with such value measured by multiplying the number of Shares underlying the Options that vested as a result of the termination of employment by the difference of the per Share Fair Market Value on the Last Day minus the applicable per Share exercise price, divided by (B) Optionee's then-current weekly base salary, plus (iii) any additional period that the Company determines to provide severance to Optionee, in its discretion.

3. In the event Optionee is discharged by Company other than with Cause prior to vesting herein of the Option, the prohibitions set forth in Sections II.B and II.C above shall remain in full force and effect.

4. After the vesting of the Option, the prohibitions on Optionee set forth herein shall remain in full force and effect, except as otherwise provided in Section II.E.

E. Effect of a Change in Control Termination on Agreements Not to Compete and Not to Solicit.

1. Notwithstanding anything set forth in Section II.D., in the event of a Change in Control Termination, the prohibitions on Optionee set forth in Section II.A shall remain in full force and effect only if the acquirer or successor to the Company following the Change in Control shall, solely at its option, pay, within thirty (30) days following Optionee's employment termination date with the Company or its successor, to Optionee the Non-Compete Payment. Notwithstanding any previous agreement between Optionee and the Company relating to the prohibitions set forth in Section II.A, the "Non-Compete Payment" shall be an amount at least equal to Optionee's then current annual base salary. Such amount shall be in addition to any other amounts paid or payable to Optionee with respect to other severance plans or policies maintained by the Company. For the avoidance of doubt, the provisions of this Section II.E shall supersede any agreement between Optionee and the Company relating to the prohibitions on Optionee set forth in Section II.A, with the exception of any similar agreement contained in (i) any employment agreement between Optionee and the Company, (ii) any agreement between Optionee and the Company not related to the employment of Optionee by the Company, (iii) any severance plan or policy of the Company and (iv) any change in control severance plan or policy of the Company.

2. In the event of a Change in Control Termination, the prohibitions on Optionee set forth in Sections II.B. and II C. shall remain in full force and effect.

F. Governing Law. Notwithstanding any other provision herein to the contrary, the provisions of this Section II of the Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Kentucky without regard to its conflicts or choice of laws rules or principles that might otherwise refer construction or interpretation of this Section II to the substantive law of another jurisdiction.

G. Injunctive Relief; Invalidity of Any Provision. Optionee acknowledges that (1) his or her services to the Company are of a special, unique and extraordinary character, (2) his or her position with the Company will place him or her in a position of confidence and trust with respect to the operations of the Company, (3) he or she will benefit from continued employment with the Company, (4) the nature and periods of restrictions imposed by the covenants contained in this Section II are fair, reasonable and necessary to protect the Company, (5) the Company would sustain immediate and irreparable loss and damage if Optionee were to breach any of such covenants, and (6) the Company's remedy at law for such a breach will be inadequate. Accordingly, Optionee agrees and consents that the Company, in addition to the recovery of damages and all other remedies available to it, at law or in equity, shall be entitled to seek both preliminary and permanent injunctions to prevent and/or halt a breach or threatened breach by Optionee of any covenant contained in Section II hereof. If any provision of this Section II is determined by a court of competent jurisdiction to be invalid in whole or in part, it shall be deemed to have been amended, whether as to time, area covered or otherwise, as and to the extent required for its validity under applicable law, and as so amended, shall be enforceable. The parties further agree to execute all documents necessary to evidence such amendment.

III. MISCELLANEOUS PROVISIONS

A. Binding Effect & Adjustment. This Agreement shall be binding and conclusive upon each successor and assign of the Company. Optionee's obligations hereunder shall not be assignable to any other person or entity. It is the intent of the parties to this Agreement that the benefits of any appreciation of the underlying Common Stock during the term of the Award shall be preserved in any event, including but not limited to a recapitalization, merger, consolidation, reorganization, stock dividend, stock split, reverse stock split, spin-off or similar transaction, or other change in corporate structure affecting the Shares, as more fully described in Sections 4.6 and 11 of the Plan. All obligations imposed upon Optionee and all rights granted to Optionee and to the Company shall be binding upon Optionee's heirs and legal representatives.

B. Amendment. This Agreement may only be amended by a writing executed by each of the parties hereto.

C. Governing Law. Except as to matters of federal law and the provisions of Section II hereof, this Agreement shall be governed by, and construed in accordance with, the laws of the State of Delaware without regard to its conflict of laws rules. This Agreement shall also be governed by, and construed in accordance with, the terms of the Plan.

D. Jurisdiction; Service of Process. Any action or proceeding seeking to enforce any provision of, or based on any right arising out of, this Agreement may be brought against any of the parties in the courts of the Commonwealth of Kentucky, County of Jefferson, or, if it has or can acquire jurisdiction, in the United States District Court for the Western District of Kentucky, and each of the parties consents to the jurisdiction of such courts (and of the appropriate appellate courts) in any such action or proceeding and waives any objection to venue laid therein. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere in the world.

E. No Employment Agreement. Nothing herein confers on Optionee any rights with respect to the continuance of employment or other service with the Company, nor will it interfere with any right the Company would otherwise have to terminate or modify the terms of Optionee's employment or other service at any time.

F. Severability. If any provision of this Agreement is or becomes or is deemed invalid, illegal or unenforceable in any relevant jurisdiction, or would disqualify this Award under any law deemed applicable by the Committee, such provision shall be construed or deemed amended to conform to applicable laws or if it cannot be construed or deemed amended without, in the determination of the Committee, materially altering the intent of the Plan, it shall be stricken and the remainder of the Agreement shall remain in full force and effect.

G. Assignment. The Option granted under this Agreement to Optionee may not be assigned, transferred, pledged, alienated or hypothecated in any manner during Optionee's lifetime, but shall be solely and exclusively the right of Optionee to exercise during his/her lifetime. Should Optionee attempt to assign, transfer, pledge, alienate or hypothecate the Option or any rights hereunder in any manner whatsoever,

such action shall constitute a breach of the covenants hereunder and the Company may terminate the Option as to any then unexercised shares.

H. Defined Terms.

1. Any term used herein and not otherwise defined herein shall have the same meaning as in the Plan. Any conflict between this Agreement and the Plan will be resolved in favor of the Plan. Any disputes or questions of right or obligation which shall result from or relate to any interpretation of this Agreement shall be determined by the Committee. Any such determination shall be binding and conclusive upon Optionee and any person or persons claiming through Optionee as to any rights hereunder.

2. For the purposes of this Agreement, the following terms shall have the following meaning:

(i) "**Change in Control Termination**" means, in the event the Option is assumed, converted, continued or substituted in connection with a Change in Control, if the employment of Optionee is terminated within two (2) years following the Change in Control (i) by the Company or its acquirer or successor for any reason other than Cause or (ii) by Optionee with Good Reason.

(ii) "**Competitive Product or Service**" means any product, process, system or service (in existence or under development) of any person or organization other than the Company that is the same as, similar to, or competes with, a product, process, system or service (in existence or under development) upon which Optionee worked or for which Optionee had responsibilities at the Company during the twenty-four (24) months prior to the Last Day (as defined below).

(iii) "**Competitor**" means Optionee or any other person or organization engaged in, or about to become engaged in, research or development, production, marketing, leasing, selling, or servicing of a Competitive Product or Service.

(iv) "**Divestiture**" means the sale or other transfer of equity securities of a Subsidiary to a person or entity other than the Company or an affiliate of the Company, or if a Subsidiary leases, exchanges or transfers all or any portion of its assets to such a person or entity, then the Committee may specify that such transaction or event constitutes a "Divestiture".

(v) "**Good Reason**" shall mean, unless otherwise defined in a written employment agreement in effect between the Company or any of its Subsidiaries and Optionee, the relocation of Optionee's office at which Optionee is to perform his or her duties to a location more than thirty (30) miles from the location at which Optionee performed his or her duties prior to a Change in Control.

(vi) "**Last Day**" means Optionee's last day of employment with the Company regardless of the reason for Optionee's separation.

(vii) "**Position Elimination**" means the elimination of Optionee's position.

(viii) "**Protected Relationship**" means policyholders, agents, brokers, dealers, distributers, sources of supply or customers with whom, within twenty-four (24) months prior to the Last

Day, Optionee, directly or indirectly (e.g., through employees whom Optionee supervised) had material business contact and/or about whom Optionee obtained confidential information and trade secrets.

(ix) "**Restricted Geographic Area**" means the territory (i.e.: (i) state(s), (ii) county(ies), or (iii) city(ies)) in which, during the twenty-four (24) months prior to the Last Day, Optionee provided material services on behalf of the Company (or in which Optionee supervised directly, indirectly, in whole or in part, the servicing activities).

(x) "**Restricted Period**" means the period of Optionee's employment with the Company and a period of twelve (12) months after the Last Day. Optionee recognizes that the durational term is reasonably and narrowly tailored to the Company's legitimate business interest and need for protection with each position.

(xi) "**Strategic Joint Venture**" means a business arrangement entered into by the Company with one or more other parties to own and operate an entity in which the Company continues to have a strategic interest.

(xii) "**Workforce Reduction**" means a reduction in force, as determined by the Company in accordance with its standard coding procedures.

I. **Execution**. If Optionee shall fail to execute this Agreement, either manually with a paper document, or through the online grant agreement procedure with the Company's designated broker–dealer, and, if manually executed, return the executed original to the Secretary of the Company, the Award shall be null and void. The choice of form will be at the Company's discretion.

IN WITNESS WHEREOF, Company has caused this Agreement to be executed on its behalf by its duly authorized officer, and Optionee has executed this Agreement, each as of the day first above written.

"Company"

ATTEST:

HUMANA INC.

BY:_____
JOSEPH C. VENTURA
Chief Legal Officer & Corporate Secretary

BY:_____
BRUCE D. BROUSSARD
President & Chief Executive Officer

"Optionee"

_____
<first_name> <middle_name> <last_name>

Exhibit 10(jj)

HUMANA INC.
COMPENSATION RECOUPMENT POLICY
(Effective February 21, 2019)

I. Policy and Scope

The Board adopts this recoupment policy under which, upon the occurrence of certain events, the Company's Officers may be required to repay to the Company certain cash and equity incentive-based compensation covered below.

Upon the occurrence of a Triggering Event, the Administrator may, in its sole discretion, after evaluating the associated costs and benefits, recover all or any portion of the Recoverable Incentive paid to a Covered Employee during the Applicable Period. In addition, the Administrator may, in its sole discretion and in the reasonable exercise of its business judgment, determine whether and to what extent additional action is appropriate to address the circumstances surrounding such Triggering Event so as to minimize the likelihood of any recurrence and to impose such other discipline as it deems appropriate.

II. Definitions

For the purposes of this Policy, the following terms have the following meanings:

A. "**Administrator**" means the Board, the Compensation Committee or such other committee of the Board that, at the relevant time, has authority for making determinations as to the compensation of senior executives.

B. "**Applicable Period**" means (i) with respect to a Restatement, the three-year period preceding the date on which the Company is required to prepare a Restatement and (ii) with respect to Improper Conduct, the three-year period preceding the date on which the Administrator determines that Improper Conduct has occurred.

C. "**Board**" means the Board of Directors of the Company.

D. "**Company**" means Humana Inc.

E. "**Compensation Committee**" means the Organization & Compensation Committee of the Board.

F. "**Covered Employee**" means any Officer of the Company.

G. "**Improper Conduct**" means the following conduct that, in the sole discretion of the Administrator, is likely to cause or has caused material financial, operational, or reputational harm to the Company, materially disrupt, damage, impair or interfere with the business of the Company or its affiliates, or have a significant, adverse reputational or economic impact on the Company or any of its affiliates or divisions:

    i. the commission of an act of fraud, misappropriation or embezzlement in the course of employment;

ii. the commission of a criminal act, whether or not in the workplace, that in the Administrator's sole discretion, constitutes a felony or crime of comparable magnitude;
iii. the material violation of a non-compete, non-solicitation, or confidentiality agreement; or
iv. the willful and material breach of a Covered Employee's obligations under the Company's code of conduct relating to compliance with law or regulation

H. "**Incentive-Based Compensation**" refers to each award of and payment (whether in cash, Company stock, or otherwise) of incentive compensation and other compensation the earning, payment or amount of which depends on the performance of the Company or any individual, product, service, or business unit, including but not limited to annual incentive compensation, awards under commission plans, and awards under the Company's stock incentive plans, including but not limited to gains from the sale or disposition of securities.

I. "**Officer**" shall include any individual who serves as a current or former "Officer" within the meaning set forth in Rule 16a-1(f) of the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), as applied by the Administrator from time to time.

J. "**Policy**" means this Humana Inc. Compensation Recoupment Policy.

K. "**Recoupment**" means, to the extent permissible under law, offset from amounts otherwise credited, payable, or due, forfeiture or cancellation of awards or amounts deferred, and/or recovery or repayment, as applicable.

L. "**Recoverable Incentive**" means (i) with respect to Recoupment relating to a Restatement, the amount of any Incentive-Based Compensation paid or provided during the Applicable Period that exceeds the amount or value that the Administrator determines, in its sole discretion, would have been payable or received in respect of Incentive-Based Compensation had the revised financial statement(s) reflected in the Restatement been applied to determine the Incentive-Based Compensation or been available to the market at the time such Incentive-Based Compensation was paid or (ii) with respect to Improper Conduct, any Incentive-Based Compensation received by the Covered Employee during and after the period in which such Improper Conduct occurred. In no event will the amount of the Recoverable Incentive exceed the total amount of Incentive-Based Compensation paid or granted during the Applicable Period.

M. "**Restatement**" means the Company being required to undertake any material restatement (occurring after the effective date of this Policy) of any of its financial statements that have been filed with the Securities and Exchange Commission (the "**SEC**") under the Exchange Act or the Securities Act of 1933, as amended.

N. "**Triggering Event**" means either a Restatement or Improper Conduct by a Covered Employee.

III. Administrator Discretion

In exercising the discretion afforded to it under this Policy, the Administrator may consider any and all facts it considers relevant under all of the circumstances, including without limitation: (A) whether or not the Covered Employee engaged in Improper Conduct; (B) the likelihood of success of any recovery under this Policy under governing law as compared to the cost and effort involved; (C) whether the assertion of a claim may prejudice the interests of the Company, including in any related proceeding or investigation; (D) the passage of time since the occurrence of the Triggering Event; and (E) any pending legal proceeding

relating to the Triggering Event. Subject to applicable law, the Administrator may seek to recoup any Recoverable Incentive by requiring any affected Covered Employee to repay such amount to the Company, by set-off, by forfeiture, by reducing future compensation, or by such other means or combination of means as the Administrator, in its sole discretion, determines to be appropriate. The Administrator has sole and absolute discretion with respect to interpretation and enforcement of this Policy and any interpretations or determinations made by the Administrator shall be final and binding on all affected individuals. This Policy will be interpreted and enforced, and appropriate disclosures and filings will be made, in a manner that is consistent with any applicable rules or regulations adopted by the SEC and the New York Stock Exchange pursuant to Section 10D of the Exchange Act, and any other applicable law (collectively, the "**Applicable Rules**"). To the extent the Applicable Rules require the Company to recover Incentive-Based Compensation in additional circumstances besides those specified herein, nothing in this Policy shall be deemed to restrict the right of the Company to recover Incentive-Based Compensation to the fullest extent required by the Applicable Rules. This Policy shall be deemed to be automatically amended, as of the date the Applicable Rules become effective with respect to the Company, to allow the Company to recover Incentive-Based Compensation to the extent required for this Policy to comply with the Applicable Rules.

IV. Recoupment

A. **Restatement**: In the event of a Restatement, the Administrator may recover up to the amount of the Recoverable Incentive received during the Applicable Period if, in the Administrator's judgment and determination, the Covered Employee engaged in fraud, negligence or other misconduct that contributed to the need for the Restatement. For the avoidance of doubt, Restatement does not include any restatement required due to changes in accounting rules or standards or changes in applicable law, or retrospective revisions or reclassifications made to reflect a change in the structure or operations of the Company.

B. **Improper Conduct**: In the event that a Covered Employee engages in Improper Conduct, the Administrator may recover up to the amount of the Recoverable Incentive during the Applicable Period.

V. Method of Recovery

The Administrator may effect Recoupment in any manner consistent with applicable law including, but not limited to, (a) seeking reimbursement of all or part of an award previously paid, (b) cancelling prior awards, whether vested or unvested or paid or unpaid, (c) cancelling or setting-off against planned future grants, and (d) any other method authorized by applicable law or contract.

VII. Amendment and Termination

The Administrator may, from time to time, suspend, discontinue, revise, amend or terminate this Policy in any respect whatsoever. Nothing in this Policy will be deemed to limit or restrict the Company from providing for recoupment, repayment and/or forfeiture of compensation (including Incentive-Based Compensation) under circumstances not set forth in this Policy. In all events, this Policy shall immediately terminate upon the consummation of a Change in Control (as defined in the Company's Change in Control Policy).

VIII. Effective Date

This Policy shall be effective as of the date it is adopted by the Board (the "**Effective Date**") and shall apply to compensation that is awarded or granted to Covered Employees on or after that date (and shall not apply to compensation that is granted or awarded before that date)

EXHIBIT 21

HUMANA INC.
SUBSIDIARY LIST

ARKANSAS
1. Humana Regional Health Plan, Inc.

CALIFORNIA
1. Humana EAP and Work-Life Services of California, Inc.
2. Humana Health Plan of California, Inc.

CONNECTICUT
1. SeniorBridge Family Companies (CT), Inc.

DELAWARE
1. Atlantis Physician Group, LLC
2. CDO 1, LLC
3. CDO 2, LLC
4. CompBenefits Corporation
5. CompBenefits Direct, Inc.
6. Emphesys, Inc.
7. Go365, LLC
8. Health Value Management, Inc.
9. HUM Provider Holdings, LLC
10. Humana at Home, Inc.
11. Humana Digital Health and Analytics Platform Services, Inc.
12. Humana Government Business, Inc.
13. Humana Inc.
14. Humana Innovation Enterprises, Inc.
15. Humana Pharmacy, Inc.
16. Humana Veterans Healthcare Services, Inc.
17. Humana WellWorks LLC
18. HumanaDental, Inc.
19. MCCI Group Holdings, LLC
20. MCCI Holdings, LLC
21. North Region Providers, LLC
22. Primary Care Holdings, Inc.
23. Primary Care Holdings II, LLC
24. Primary Care Specialists of the Palm Beaches, LLC
25. Transcend Population Health Management, LLC
26. Transcend Population Health Management II, LLC

FLORIDA
1. 154th Street Medical Plaza, Inc.
2. 54th Street Medical Plaza, Inc.
3. American Eldercare of North Florida, LLC
4. American Eldercare, Inc.
5. CAC Medical Center Holdings, Inc.
6. CAC-Florida Medical Centers, LLC
7. Care Partners Home Care, LLC
8. CarePlus Health Plans, Inc.
9. CompBenefits Company
10. Complex Clinical Management, Inc.
11. Continucare Corporation
12. Continucare MDHC, LLC
13. Continucare Medical Management, Inc.

14. Continucare MSO, Inc.
15. Family Physicians of Winter Park, Inc.
16. FPG Acquisition Corp.
17. FPG Acquisition Holdings Corp.
18. FPG Holding Company, LLC
19. FPG Senior Services, LLC
20. HUM-e-FL, Inc.
21. Humana At Home 1, Inc.
22. Humana Dental Company
23. Humana Health Insurance Company of Florida, Inc.
24. Humana Medical Plan, Inc.
25. MCCI Specialty, LLC
26. MCCI/Lifetime of Aventura, LLC
27. METCARE of Florida, Inc.
28. Metropolitan Health Networks, Inc.
29. Naples Health Care Specialists, LLC
30. Nursing Solutions, LLC
31. Partners in Integrated Care, Inc.
32. RMA Medical Centers of Florida, LLC
33. RMA Medical Group of Florida, LLC
34. SeniorBridge Family Companies (FL), Inc.
35. SeniorBridge-Florida, LLC

GEORGIA
1. Humana Employers Health Plan of Georgia, Inc.

ILLINOIS
1. CompBenefits Dental, Inc.
2. Dental Care Plus Management, Corp.
3. Humana Benefit Plan of Illinois, Inc.
4. Humana Healthcare Research, Inc.

INDIANA
1. SeniorBridge Family Companies (IN), Inc.

KENTUCKY
1. 516-526 West Main Street Condominium Council of Co-Owners, Inc.
2. CHA HMO, Inc.
3. CHA Service Company
4. Humana Active Outlook, Inc.
5. Humana Health Plan, Inc.
6. Humana Insurance Company of Kentucky
7. Humana MarketPOINT, Inc.
8. Humana Pharmacy Solutions, Inc.
9. Humco, Inc.
10. Preservation on Main, Inc.
11. The Dental Concern, Inc.

LOUISIANA
1. Humana Health Benefit Plan of Louisiana, Inc.

MICHIGAN
1. Humana Medical Plan of Michigan, Inc.

MISSOURI
1. SeniorBridge Family Companies (MO), Inc.

NEW YORK
1. Harris, Rothenberg International Inc.
2. Humana Health Company of New York, Inc.
3. Humana Insurance Company of New York
4. SeniorBridge Family Companies (NY), Inc.

OHIO
1. Humana Health Plan of Ohio, Inc.
2. Hummingbird Coaching Systems LLC

PENNSYLVANIA
1. Humana Medical Plan of Pennsylvania, Inc.

PUERTO RICO
1. Humana Health Plans of Puerto Rico, Inc.
2. Humana Insurance of Puerto Rico, Inc.
3. Humana Management Services of Puerto Rico, Inc.
4. Humana MarketPOINT of Puerto Rico, Inc.

TENNESSEE
1. Cariten Health Plan Inc.
2. PHP Companies, Inc.
3. Preferred Health Partnership, Inc.

TEXAS
1. CompBenefits Insurance Company
2. DentiCare, Inc.
3. Emphesys Insurance Company
4. Humana At Home (Dallas), Inc.
5. Humana At Home (Houston), Inc.
6. Humana At Home (San Antonio), Inc.
7. Humana At Home (TLC), Inc.
8. Humana Behavioral Health, Inc.
9. Humana Health Plan of Texas, Inc.
10. Medical Care Consortium Incorporated of Texas
11. ROHC, L.L.C.
12. Texas Dental Plans, Inc.

UTAH
1. Humana Medical Plan of Utah, Inc.

VERMONT
1. Managed Care Indemnity, Inc.

WASHINGTON
1. Arcadian Health Plan, Inc.

WISCONSIN
1. CareNetwork, Inc.
2. Humana Insurance Company
3. Humana Wisconsin Health Organization Insurance Corporation
4. HumanaDental Insurance Company
5. Independent Care Health Plan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 33-49305, No. 333-04435, No. 333-57095, No. 333-86801, No. 333-41408, No. 333-86280, No. 333-105622, No. 333-134887, No. 333-162747, No. 333-171616, and No. 333-175350) and S-3 (No. 333-223554) of Humana Inc. of our report dated February 21, 2019 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky

February 21, 2019

Exhibit 31.1

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Bruce D. Broussard, principal executive officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 21, 2019

Signature: /s/ BRUCE D. BROUSSARD

Bruce D. Broussard
Principal Executive Officer

Exhibit 31.2

CERTIFICATION PURSUANT TO SECTION 302 OF SARBANES-OXLEY ACT OF 2002

I, Brian A. Kane, principal financial officer of Humana Inc., certify that:

1. I have reviewed this annual report on Form 10-K of Humana Inc.;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 21, 2019

Signature: /s/ BRIAN A. KANE

Brian A. Kane
Principal Financial Officer

Exhibit 32

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of Humana Inc. (the "Company") on Form 10-K for the period ended December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned hereby certifies, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, in his capacity as an officer of Humana Inc., that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ BRUCE D. BROUSSARD

Bruce D. Broussard
President and Chief Executive Officer,
Director (Principal Executive Officer)

February 21, 2019

/s/ BRIAN A. KANE

Brian A. Kane
Chief Financial Officer
(Principal Financial Officer)

February 21, 2019

A signed original of this written statement required by Section 906 has been provided to Humana Inc. and will be retained by Humana Inc. and furnished to the Securities and Exchange Commission or its staff upon request.