HUMANA INC
Form 10-K
February 17, 2017
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K
þ 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 þ 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 þ
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 þ 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 þ 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. þ
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 þ 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 þ
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.
INDEX TO ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2016

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.

6

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

9

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 (in thousands)						Group Segment					
	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

18

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

30

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		

Total revenues	4,816,008	2,326,563	2,189,827	1,164,312	(2,145,898)	8,3
Operating expenses:						
Benefits	3,879,424	1,818,752	0	1,021,082	(77,994)	6,(
Operating costs	461,038	407,117	2,106,079	118,551	(2,090,387)	1,(
Depreciation and amortization	27,625	21,704	8,211	2,664	(1,487)	
Total operating expenses	4,368,087	2,247,573	2,114,290	1,142,297	(2,169,868)	7,7
Income from operations	447,921	78,990	75,537	22,015	23,970	(
Interest expense	0	0	0	0	26,143	
Income (loss) before income taxes	$ 447,921	$ 78,990	$ 75,537	$ 22,015	$ (2,173)	$ (

Table of Contents

Humana Inc.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

	Retail	Employer Group	Health and Well-Being Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in thousands)			
Nine months ended September 30, 2011						
Revenues - external customers						
Premiums:						
Medicare Advantage	$ 13,645,876	$ 2,364,306	$ 0	$ 0	$ 0	$ 16,010,182
Medicare stand-alone PDP	1,737,603	5,638	0	195,604	0	1,938,845
Total Medicare	15,383,479	2,369,944	0	195,604	0	17,949,027
Fully-insured	628,811	3,600,476	0	0	0	4,229,287
Specialty	88,504	697,934	0	0	0	786,438
Military services	0	0	0	2,801,999	0	2,801,999
Medicaid and other	0	0	0	701,452	0	701,452
Total premiums	16,100,794	6,668,354	0	3,699,055	0	26,468,203
Services revenue:						
Provider	0	0	671,055	0	0	671,055
ASO and other	11,364	267,902	0	76,659	0	355,925
Pharmacy	0	0	7,683	0	0	7,683
Total services revenue	11,364	267,902	678,738	76,659	0	1,034,663
Total revenues - external customers	16,112,158	6,936,256	678,738	3,775,714	0	27,502,866
Intersegment revenues						
Services	0	10,313	6,324,992	0	(6,335,305)	0
Products	0	0	1,329,722	0	(1,329,722)	0
Total intersegment revenues	0	10,313	7,654,714	0	(7,665,027)	0
Investment income	56,968	35,287	0	39,999	140,372	272,626
Total revenues	16,169,126	6,981,856	8,333,452	3,815,713	(7,524,655)	27,775,492
Operating expenses:						
Benefits	13,193,598	5,408,049	0	3,375,461	(216,056)	21,761,052
Operating costs	1,625,423	1,216,685	8,004,784	351,145	(7,388,132)	3,809,905
Depreciation and amortization	88,598	64,101	60,927	6,802	(19,867)	200,561
Total operating expenses	14,907,619	6,688,835	8,065,711	3,733,408	(7,624,055)	25,771,518
Income from operations	1,261,507	293,021	267,741	82,305	99,400	2,003,974
Interest expense	0	0	0	0	81,956	81,956

Income before income taxes	$ 1,261,507	$ 293,021	$ 267,741	$ 82,305	$ 17,444	$ 1,922,018

Table of Contents

Humana Inc.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Unaudited

	Retail	Employer Group	Health and Well-Being Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in thousands)			
Nine months ended September 30, 2010						
Revenues - external customers						
Premiums:						
Medicare Advantage	$ 12,241,366	$ 2,259,733	$ 0	$ 0	$ 0	$ 14,501,099
Medicare stand-alone PDP	1,512,738	3,443	0	342,649	0	1,858,830
Total Medicare	13,754,104	2,263,176	0	342,649	0	16,359,929
Fully-insured	551,581	3,904,705	0	0	0	4,456,286
Specialty	58,853	663,055	0	0	0	721,908
Military services	0	0	0	2,603,950	0	2,603,950
Medicaid and other	0	0	0	531,186	0	531,186
Total premiums	14,364,538	6,830,936	0	3,477,785	0	24,673,259
Services revenue:						
Provider	0	0	9,869	0	0	9,869
ASO and other	8,457	294,241	0	82,072	0	384,770
Pharmacy	0	0	0	0	0	0
Total services revenue	8,457	294,241	9,869	82,072	0	394,639
Total revenues - external customers	14,372,995	7,125,177	9,869	3,559,857	0	25,067,898
Intersegment revenues						
Services	0	9,892	5,674,965	0	(5,684,857)	0
Products	0	0	936,673	0	(936,673)	0
Total intersegment revenues	0	9,892	6,611,638	0	(6,621,530)	0
Investment income	62,002	32,412	0	31,363	126,718	252,495
Total revenues	14,434,997	7,167,481	6,621,507	3,591,220	(6,494,812)	25,320,393
Operating expenses:						
Benefits	11,796,751	5,586,593	0	3,125,564	(181,166)	20,327,742
Operating costs	1,512,779	1,250,446	6,427,167	348,611	(6,382,058)	3,156,945
Depreciation and amortization	86,826	70,219	19,703	8,684	(3,475)	181,957
Total operating expenses	13,396,356	6,907,258	6,446,870	3,482,859	(6,566,699)	23,666,644
Income from operations	1,038,641	260,223	174,637	108,361	71,887	1,653,749
Interest expense	0	0	0	0	78,679	78,679

Income (loss) before income taxes	$ 1,038,641	$ 260,223	$ 174,637	$ 108,361	$ (6,792)	$ 1,575,070

Retail segment operating costs for the nine months ended September 30, 2010 include $147.5 million for the write-down of deferred acquisition costs associated with our individual commercial medical policies as discussed more fully in Note 18 to the consolidated financial statements included in our 2010 Form 10-K.

Table of Contents

Humana Inc.

MANAGEMENT S DISCUSSION AND ANALYSIS OF

FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The condensed consolidated financial statements of Humana Inc. in this document present the Company s financial position, results of operations and cash flows, and should be read in conjunction with the following discussion and analysis. References to we, us, our, Company, and Humana mean Humana Inc. and its subsidiaries. This discussion includes forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. When used in filings with the SEC, in our press releases, investor presentations, and in oral statements made by or with the approval of one of our executive officers, the words or phrases like expects, anticipates, intends, likely will result, estimat projects or variations of such words and similar expressions are intended to identify such forward looking statements. These forward looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including, among other things, information set forth in Item 1A. Risk Factors in our 2010 Form 10-K, as modified by any changes to those risk factors included in this document and in other reports we filed subsequent to February 17, 2011, in each case incorporated by reference herein. In making these statements, we are not undertaking to address or update these factors in future filings or communications regarding our business or results. In light of these risks, uncertainties and assumptions, the forward looking events discussed in this document might not occur. There may also be other risks that we are unable to predict at this time. Any of these risks and uncertainties may cause actual results to differ materially from the results discussed in the forward looking statements.

Executive Overview

General

Headquartered in Louisville, Kentucky, Humana is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. By leveraging the strengths of our core businesses, we believe that we can better explore opportunities for existing and emerging adjacencies in health care that can further enhance wellness opportunities for the millions of people across the nation with whom we have relationships.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefit expenses 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 as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

2011 Business Segment Realignment

During the first quarter of 2011, we realigned our business segments to reflect our evolving business model. As a result, we reassessed and changed our operating and reportable segments in the first quarter of 2011 to reflect management s new view of the business and to align our external financial reporting with our new operating and internal financial reporting model. Historical segment information has been retrospectively adjusted to reflect the effect of this change. Our new reportable segments and the basis for determining those segments are discussed below.

Business Segments

We currently manage our business with three reportable segments: Retail, Employer Group, and Health and Well-Being Services. In addition, we include other businesses that are not reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles in an Other Businesses category. 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 and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals. The Employer Group segment consists of Medicare and commercial fully-insured medical and

27

Table of Contents

specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, as well as administrative services only products marketed to employer groups. The Health and Well-Being Services segment includes services offered to our health plan members as well as to third parties that promote health and wellness, including primary care, pharmacy, integrated wellness, and home care services. The Other Businesses category consists of our Military services, primarily our TRICARE South Region contract, Medicaid, and closed-block long-term care businesses as well as our contract with CMS to administer the LI-NET program.

The results of each segment are measured by income before income taxes. Transactions between reportable segments consist of sales of services rendered by our Health and Well-Being Services segment, primarily pharmacy and behavioral health services, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize 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 do not report total assets by segment since this is not a metric used to assess performance and allocate resources. We allocate most operating expenses to our segments. Certain corporate income and expenses are not allocated to the segments, including investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at the corporate level. These corporate amounts are reported separately from our reportable segments and included with intersegment eliminations.

Seasonality

Our Retail segment offers Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. These plans provide varying degrees of coverage. 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 affect the quarterly benefit ratio pattern.

2011 Highlights

Consolidated

We experienced favorable prior-period medical claims reserve development of approximately $34 million, or $0.13 per diluted common share, for the three months ended September 30, 2011 as compared to $84 million, or $0.31 per diluted common share, for the three months ended September 30, 2010. For the nine months ended September 30, 2011, we experienced favorable prior-period development of approximately $151 million, or $0.57 per diluted common share, compared to $194 million, or $0.72 per diluted common share, for the nine months ended September 30, 2010.

In April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy and we subsequently paid a cash dividend of $0.25 per share to stockholders of record on each of June 30, 2011 and September 30, 2011.

In addition, in April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion. The new authorization will expire June 30, 2013. As of October 31, 2011, the remaining authorized amount under the new authorization totaled $561.3 million.

Our year-to-date comparisons are impacted by the $147.5 million write-down of deferred acquisition costs associated with our individual commercial medical policies during the nine months ended September 30, 2010 as discussed more fully in Note 18 to the consolidated financial statements included in our 2010 Form 10-K.

Table of Contents

Retail

On April 4, 2011, CMS announced that Medicare Advantage payment rates will increase on average 0.4% sector-wide in 2012. We believe we effectively designed Medicare Advantage products based upon this level of rate increase while continuing to remain competitive compared to both the combination of original Medicare with a supplement policy as well as other Medicare Advantage competitors within our industry. In addition, we will continue to pursue our cost-reduction and outcome-enhancing strategies, including care coordination and disease management, which we believe will mitigate the adverse effects of the rates on our Medicare Advantage members. Nonetheless, there can be no assurance that we will be able to successfully execute operational and strategic initiatives with respect to changes in the Medicare Advantage program. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

Individual Medicare Advantage membership of 1,613,400 at September 30, 2011 increased 152,700 members, or 10.5%, from 1,460,700 at December 31, 2010 and increased 151,200, or 10.3%, from 1,462,200 at September 30, 2010 primarily due to a successful enrollment season associated with the 2011 plan year.

Individual Medicare stand-alone PDP membership of 2,478,100 at September 30, 2011 increased 807,800 members, or 48.4%, from 1,670,300 at December 31, 2010 and increased 789,900, or 46.8%, from 1,688,200 at September 30, 2010, primarily due to sales of our new lowest premium national stand-alone Medicare Part D prescription drug plan co-branded with Wal-Mart Stores, Inc., the Humana Walmart-Preferred Rx Plan, that we began offering for the 2011 plan year.

Our year-to-date Retail segment comparisons are impacted by the $147.5 million write-down of deferred acquisition costs associated with our individual commercial medical policies during the nine months ended September 30, 2010 as discussed above.

During the third quarter of 2011, we entered into definitive agreements to acquire the California-based Medicare Advantage health maintenance organizations (HMO) Arcadian Management Services, Inc. and MD Care, Inc. These companies, on a combined basis, serve approximately 79,000 Medicare Advantage HMO members in 15 U.S. states, and offer us an opportunity to expand our Medicare footprint and grow our Medicare enrollment. The closings of these acquisitions are subject to federal and/or state regulatory approvals.

Other Businesses

As more fully discussed in Note 12 to the condensed consolidated financial statements, on February 25, 2011, the TMA awarded the TRICARE South Region contract to us. On March 7, 2011, the competing bidder filed a protest of the award with the GAO. Also on March 7, 2011, as provided in the Federal Acquisition Regulations, TMA issued a stop work order to us in connection with the award. On June 14, 2011, the GAO upheld the award of the contract to us and TMA subsequently lifted the stop work order. On June 21, 2011, the competing bidder filed a complaint in the United States Court of Federal Claims objecting to the award of the contract to us. On October 14, 2011, the Court upheld the award of the contract to us, and the competing bidder has until December 13, 2011 to appeal it in the Court of Appeals for the Federal Circuit. As a result of the award of the TRICARE South Region contract to us, we no longer expect a goodwill impairment to occur during the second half of 2011. Ultimate disposition of the contract award is, however, subject to the resolution of any additional actions the unsuccessful bidder may take.

Health Insurance Reform

In March 2010, the President signed into law 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 Insurance Reform Legislation) which enact significant reforms to various aspects of the U.S. health insurance industry. While regulations and interpretive guidance on some provisions of the Health Insurance Reform Legislation have been issued to date by the Department of Health and Human Services (HHS), the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners, there are many significant provisions of the legislation that will require additional guidance and clarification in the form of regulations and interpretations in order to fully understand the impacts of the legislation on our overall business,

which we expect to occur over the next several years.

Table of Contents

Implementation dates of the Health Insurance Reform Legislation vary from as early as six months from the date of enactment, or September 23, 2010, to as late as 2018. The following outlines certain provisions of the Health Insurance Reform Legislation:

- Changes effective for plan years beginning on or after September 23, 2010 included: elimination of pre-existing condition limits for enrollees under age 19, elimination of certain annual and lifetime caps on the dollar value of benefits, expansion of dependent coverage to include adult children until age 26, a requirement to provide coverage for preventive services without cost to members, new claim appeal requirements, and the establishment of an interim high risk program for those unable to obtain coverage due to a pre-existing condition or health status.

- Effective January 1, 2011, minimum benefit ratios were mandated for all commercial fully-insured medical plans in the large group (85%), small group (80%), and individual (80%) markets, with annual rebates to policyholders if the actual benefit ratios, calculated in a manner prescribed by HHS, do not meet these minimums. Beginning in 2011, we accrued for rebates, based on the manner prescribed by HHS, with initial rebate payments to be made in mid-2012. Our benefit ratios reported herein, calculated from financial statements prepared in accordance with accounting principles generally accepted in the United States of America, or GAAP, differ from the benefit ratios calculated as prescribed by HHS under the Health Insurance Reform Legislation. The more noteworthy differences include the fact that the benefit ratio calculations prescribed by HHS are calculated separately by state and legal entity; reflect actuarial adjustments where the membership levels are not large enough to create credible size; exclude some of our health insurance products; include taxes and fees as reductions of premium; treat changes in reserves differently than GAAP; and classify rebate amounts as additions to incurred claims as opposed to adjustments to premiums for GAAP reporting.

- Medicare Advantage payment benchmarks for 2011 were frozen at 2010 levels and beginning in 2012, additional cuts to Medicare Advantage plan payments will begin to take effect (plans will receive a range of 95% in high-cost areas to 115% in low-cost areas of Medicare fee-for-service rates), with changes being phased-in over two to six years, depending on the level of payment reduction in a county. In addition, beginning in 2011, the gap in coverage for Medicare Part D prescription drug coverage has begun to incrementally close.

- Beginning in 2014, the Health Insurance Reform Legislation requires: all individual and group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments; the elimination of annual limits on coverage on certain plans; the establishment of state-based exchanges for individuals and small employers (with up to 100 employees); the introduction of standardized plan designs based on set actuarial values; the establishment of a minimum benefit ratio of 85% for Medicare Advantage plans; and insurance industry assessments, including an annual premium-based assessment ($8 billion levied on the insurance industry in 2014 with increasing annual amounts thereafter), which is not deductible for income tax purposes.

The Health Insurance Reform Legislation also specifies required benefit designs, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and expands eligibility for Medicaid programs. In addition, the law will significantly 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 insurers, health plans and individuals beginning in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described above.

In addition, certain provisions in the Health Insurance Reform Legislation tie Medicare Advantage premiums to the achievement of certain quality performance measures (Star Ratings). Beginning in 2012, Medicare Advantage plans with an overall Star Rating of three or more stars (out of five) will be eligible for a quality bonus in their basic premium rates. Initially quality bonuses were limited to the few plans that achieved four or more stars as an overall rating, but CMS has expanded the quality bonus to three Star plans for a three year period through 2014.

Table of Contents

Notwithstanding successful efforts to improve our Star Ratings and other quality measures for 2012 and 2013 and the continuation of such efforts, there can be no assurances that we will be successful in maintaining or improving our Star Ratings in future years. 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.

As discussed above, implementing regulations and related interpretive guidance continue to be issued on several significant provisions of the Health Insurance Reform Legislation, and certain aspects of the Health Insurance Reform Legislation are also being challenged in federal court, seeking to limit the scope of or have all or portions of the Health Insurance Reform Legislation declared unconstitutional. Judicial proceedings are subject to appeal and could last for an extended period of time, and we cannot predict the results of any of these proceedings. Congress may also withhold the funding necessary to implement the Health Insurance Reform Legislation, or may attempt to replace the legislation with amended provisions or repeal it altogether. Given the breadth of possible changes and the uncertainties of interpretation, implementation, and timing of these changes, which we expect to occur over the next several years, the Health Insurance Reform Legislation could change the way we do business, potentially impacting our pricing, benefit design, product mix, geographic mix, and distribution channels. The response of other companies to the Health Insurance Reform Legislation and adjustments to their offerings, if any, could cause meaningful disruption in the local health care markets. Further, various health insurance reform proposals are also emerging at the state level. It is reasonably possible that the Health Insurance Reform Legislation and related regulations, as well as future legislative changes, 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 administrative costs, lowering our Medicare payment rates and increasing our expenses associated with the non-deductible federal premium tax and other assessments; our financial position, including our ability to maintain the value of our goodwill; and our cash flows. If the new non-deductible federal premium tax is imposed as enacted, and if we are unable to adjust our business model to address this new tax, there can be no assurance that the non-deductible federal premium tax would not have a material adverse effect on our results of operations, financial position, and 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.

Table of Contents

Comparison of Results of Operations for 2011 and 2010

The following discussion primarily deals with our results of operations for the three months ended September 30, 2011, or the 2011 quarter, the three months ended September 30, 2010, or the 2010 quarter, the nine months ended September 30, 2011, or the 2011 period, and the nine months ended September 30, 2010, or the 2010 period.

Consolidated

	For the three months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(dollars in thousands)			
Revenues:				
Premiums:				
Retail	$ 5,399,654	$ 4,791,627	$ 608,027	12.7%
Employer Group	2,225,202	2,217,290	7,912	0.4%
Other Businesses	1,227,680	1,125,728	101,952	9.1%
Total premiums	8,852,536	8,134,645	717,891	8.8%
Services:				
Retail	4,597	3,116	1,481	47.5%
Employer Group	88,699	94,884	(6,185)	(6.5)%
Health and Well-Being Services	236,472	3,815	232,657	nm
Other Businesses	26,444	27,102	(658)	(2.4)%
Total services	356,212	128,917	227,295	176.3%
Investment income	91,895	87,250	4,645	5.3%
Total revenues	9,300,643	8,350,812	949,831	11.4%
Operating expenses:				
Benefits	7,146,530	6,641,264	505,266	7.6%
Operating costs	1,361,657	1,002,398	359,259	35.8%
Depreciation and amortization	66,671	58,717	7,954	13.5%
Total operating expenses	8,574,858	7,702,379	872,479	11.3%
Income from operations	725,785	648,433	77,352	11.9%
Interest expense	27,065	26,143	922	3.5%
Income before income taxes	698,720	622,290	76,430	12.3%
Provision for income taxes	253,960	229,069	24,891	10.9%
Net income	$ 444,760	$ 393,221	$ 51,539	13.1%
Diluted earnings per common share	$ 2.67	$ 2.32	$ 0.35	15.1%
Benefit ratio(a)	80.7%	81.6%		(0.9)%
Operating cost ratio(b)	14.8%	12.1%		2.7%
Effective tax rate	36.3%	36.8%		(0.5)%

32

Table of Contents

	For the nine months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(dollars in thousands)			
Revenues:				
Premiums:				
Retail	$ 16,100,794	$ 14,364,538	$ 1,736,256	12.1%
Employer Group	6,668,354	6,830,936	(162,582)	(2.4)%
Other Businesses	3,699,055	3,477,785	221,270	6.4%
Total premiums	26,468,203	24,673,259	1,794,944	7.3%
Services:				
Retail	11,364	8,457	2,907	34.4%
Employer Group	267,902	294,241	(26,339)	(9.0)%
Health and Well-Being Services	678,738	9,869	668,869	nm
Other Businesses	76,659	82,072	(5,413)	(6.6)%
Total services	1,034,663	394,639	640,024	162.2%
Investment income	272,626	252,495	20,131	8.0%
Total revenues	27,775,492	25,320,393	2,455,099	9.7%
Operating expenses:				
Benefits	21,761,052	20,327,742	1,433,310	7.1%
Operating costs	3,809,905	3,156,945	652,960	20.7%
Depreciation and amortization	200,561	181,957	18,604	10.2%
Total operating expenses	25,771,518	23,666,644	2,104,874	8.9%
Income from operations	2,003,974	1,653,749	350,225	21.2%
Interest expense	81,956	78,679	3,277	4.2%
Income before income taxes	1,922,018	1,575,070	346,948	22.0%
Provision for income taxes	701,795	583,005	118,790	20.4%
Net income	$ 1,220,223	$ 992,065	$ 228,158	23.0%
Diluted earnings per common share	$ 7.24	$ 5.84	$ 1.40	24.0%
Benefit ratio(a)	82.2%	82.4%		(0.2)%
Operating cost ratio(b)	13.9%	12.6%		1.3%
Effective tax rate	36.5%	37.0%		(0.5)%

(a) Represents total benefit expenses as a percentage of premium revenues.
(b) Represents total operating costs as a percentage of total revenues less investment income.
nm not meaningful

Table of Contents

Summary

Net income was $444.8 million, or $2.67 per diluted common share, in the 2011 quarter compared to $393.2 million, or $2.32 per diluted common share, in the 2010 quarter. Net income was $1.2 billion, or $7.24 per diluted common share, in the 2011 period compared to $992.1 million, or $5.84 per diluted common share, in the 2010 period. The increases during the 2011 quarter and period primarily were due to improved operating performance in the Retail and Health and Well-Being Services segments. Our diluted earnings per common share include the beneficial impact of favorable prior-period medical claims reserve development of approximately $0.13 per diluted common share for the 2011 quarter compared to $0.31 per diluted common share for the 2010 quarter and $0.57 per diluted common share for the 2011 period compared to $0.72 per diluted common share for the 2010 period. Net income for the 2010 period also included the negative impact of a $147.5 million ($0.55 per diluted common share) write-down of deferred acquisition costs associated with our individual commercial medical policies in our Retail Segment.

Premiums

Consolidated premiums increased $717.9 million, or 8.8%, from the 2010 quarter to $8.9 billion for the 2011 quarter, and increased $1.8 billion, or 7.3%, from the 2010 period to $26.5 billion for the 2011 period. The increases primarily were due to a $608.0 million, or 12.7%, and $1.7 billion, or 12.1%, year-over-year increase in Retail segment premiums for the 2011 quarter and period, respectively, partially offset by a decline in Employer Group segment premiums in the 2011 period. The increase in Retail segment premiums primarily resulted from higher average individual Medicare Advantage membership. The decrease in Employer Group segment premiums primarily resulted from lower average fully-insured commercial group medical membership. 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.

Services Revenue

Consolidated services revenue increased $227.3 million from the 2010 quarter to $356.2 million for the 2011 quarter. For the 2011 period, services revenue was $1.0 billion, an increase of $640.0 million, or 162.2%, compared to the 2010 period. The increases during the 2011 quarter and period were primarily the result of the increase in primary care services revenue in our Health and Well-Being Services segment, primarily as a result of the acquisition of Concentra on December 21, 2010.

Investment Income

Investment income totaled $91.9 million for the 2011 quarter, an increase of $4.6 million from the 2010 quarter, primarily due to higher interest rates. For the 2011 period, investment income totaled $272.6 million, an increase of $20.1 million from the 2010 period primarily reflecting higher interest rates as well as higher average invested balances as a result of the reinvestment of operating cash flow.

Benefit Expenses

Consolidated benefit expenses were $7.1 billion for the 2011 quarter, an increase of $505.3 million, or 7.6%, from the 2010 quarter. For the 2011 period, consolidated benefit expenses increased by $1.4 billion, or 7.1%, from the 2010 period to $21.8 billion. The increases were primarily due to a $369.8 million, or 9.5%, and $1.4 billion, or 11.8%, year-over-year increase in Retail segment benefit expenses in the 2011 quarter and period, respectively, primarily driven by an increase in the average number of Medicare members.

The consolidated benefit ratio was 80.7% for the 2011 quarter, decreasing 90 basis points from the 2010 period, and 82.2% for the 2011 period, decreasing 20 basis points from the comparable 2010 period primarily driven by a decline in the Retail segment benefit ratio, particularly for our individual Medicare Advantage products, partially offset by lower favorable prior-period medical claims reserve development in the 2011 quarter and period than in the 2010 quarter and period on a consolidated basis.

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.

Table of Contents

Consolidated operating costs increased $359.3 million, or 35.8%, during the 2011 quarter compared to the 2010 quarter. For the 2011 period, consolidated operating costs increased $653.0 million, or 20.7%, compared to the 2010 period. The increases primarily were due to an increase in operating costs in our Health and Well-Being Segment as a result of the acquisition of Concentra on December 21, 2010, as well as an increase in operating costs in our Retail segment as a result of increased expenses associated with the Medicare sales season for 2012 offerings which began a month earlier than in the prior year. The 2010 period includes $147.5 million of operating costs for the write-down of deferred acquisition costs associated with our individual commercial medical policies in our Retail Segment.

The consolidated operating cost ratio for the 2011 quarter was 14.8%, an increase of 270 basis points from the 2010 quarter. For the 2011 period, the consolidated operating cost ratio was 13.9%, a 130 basis point increase from the 2010 period. The $147.5 million write-down of deferred acquisition costs in the 2010 period increased the operating cost ratio 60 basis points for the 2010 period. Excluding the impact of the write-down of deferred acquisition costs in 2010, the increases primarily reflect the greater percentage of our revenues derived from Concentra, acquired December 21, 2010, in our Health and Well-Being Services segment, which carries a higher operating cost ratio on external revenues than our other business segments, as well as an increase in the Retail segment operating cost ratio.

Depreciation and Amortization

Depreciation and amortization for the 2011 quarter totaled $66.7 million, an increase of $8.0 million, or 13.5%, from the 2010 quarter. Depreciation and amortization for the 2011 period totaled $200.6 million, an increase of $18.6 million or 10.2% from the 2010 period. The increases primarily reflect depreciation and amortization expense associated with our Concentra operations, acquired on December 21, 2010.

Interest Expense

Interest expense was $27.1 million for the 2011 quarter, increasing $0.9 million, or 3.5% from the 2010 quarter, and $82.0 million for the 2011 period, increasing $3.3 million, or 4.2%, from the 2010 period.

Income Taxes

Our effective tax rate during the 2011 quarter was 36.3% compared to the effective tax rate of 36.8% in the 2010 quarter. The effective tax rate for the 2011 period of 36.5% declined from 37.0% for the 2010 period. The higher tax rate for the 2010 period primarily was due to the cumulative adjustment associated with estimating the retrospective aspect of new limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Insurance Reform Legislation.

Table of Contents

Retail Segment

	$0,000,000	$0,000,000	$0,000,000	$0,000,000
	September 30,		Change	
	2011	2010	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	1,613,400	1,462,200	151,200	10.3%
Individual Medicare stand-alone PDP	2,478,100	1,688,200	789,900	46.8%
Total individual Medicare	4,091,500	3,150,400	941,100	29.9%
Individual commercial	480,700	412,700	68,000	16.5%
Total medical members	4,572,200	3,563,100	1,009,100	28.3%
Individual specialty membership(a)	755,600	487,000	268,600	55.2%

(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.

	For the three months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(in thousands)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 4,566,087	$ 4,075,532	$ 490,555	12.0%
Individual Medicare stand-alone PDP	578,786	504,929	73,857	14.6%
Total individual Medicare	5,144,873	4,580,461	564,412	12.3%
Individual commercial	221,632	189,503	32,129	17.0%
Individual specialty	33,149	21,663	11,486	53.0%
Total premiums	5,399,654	4,791,627	608,027	12.7%
Services	4,597	3,116	1,481	47.5%
Total premiums and services revenue	$ 5,404,251	$ 4,794,743	$ 609,508	12.7%
Income before income taxes	$ 541,449	$ 447,921	$ 93,528	20.9%
Benefit ratio	78.7%	81.0%		(2.3)%
Operating cost ratio	11.2%	9.6%		1.6%

	For the nine months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(in thousands)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 13,645,876	$ 12,241,366	$ 1,404,510	11.5%

Individual Medicare stand-alone PDP	1,737,603	1,512,738	224,865	14.9%
Total individual Medicare	15,383,479	13,754,104	1,629,375	11.8%
Individual commercial	628,811	551,581	77,230	14.0%
Individual specialty	88,504	58,853	29,651	50.4%
Total premiums	16,100,794	14,364,538	1,736,256	12.1%
Services	11,364	8,457	2,907	34.4%
Total premiums and services revenue	$ 16,112,158	$ 14,372,995	$ 1,739,163	12.1%
Income before income taxes	$ 1,261,507	$ 1,038,641	$ 222,866	21.5%
Benefit ratio	81.9%	82.1%		(0.2)%
Operating cost ratio	10.1%	10.5%		(0.4)%

Table of Contents

Pretax Results

Retail segment pretax income was $541.4 million in the 2011 quarter, an increase of $93.5 million, or 20.9%, compared to $447.9 million in the 2010 quarter. For the 2011 period, the Retail segment s pretax income was $1.3 billion compared to $1.0 billion in the 2010 period, an increase of $0.3 billion, or 21.5%. These increases were primarily driven by higher average individual Medicare membership and a lower benefit ratio, discussed below, partially offset by increased expenses associated with the Medicare sales season for 2012 offerings which began a month earlier than in the prior year. Pretax income for the 2010 period included the negative impact of a $147.5 million write-down of deferred acquisition costs associated with our individual commercial medical policies. In addition, the Retail segment s pretax income for the 2011 quarter and period included the beneficial effect of an estimated $32 million and $104 million, respectively, in favorable prior-period medical claims reserve development versus $63 million and $165 million in the 2010 quarter and period, respectively.

Enrollment

Individual Medicare Advantage membership increased 151,200 members, or 10.3%, from September 30, 2010 to September 30, 2011 due to a successful enrollment season associated with the 2011 plan year.

Individual Medicare stand-alone PDP membership increased 789,900 members, or 46.8%, from September 30, 2010 to September 30, 2011 primarily from higher gross sales year-over-year, particularly due to our low-price-point Humana Walmart-Preferred Rx Plan that we began offering for the 2011 plan year.

Individual specialty membership increased 268,600, or 55.2%, from September 30, 2010 to September 30, 2011 primarily driven by increased sales in dental and vision offerings.

Premiums

Retail segment premiums increased $608.0 million, or 12.7%, from the 2010 quarter to the 2011 quarter and increased $1.7 billion, or 12.1%, from the 2010 period to the 2011 period. The increases primarily were due to a 10.0% increase for both the 2011 quarter and period in average individual Medicare Advantage membership compared to the 2010 quarter and period. Individual Medicare stand-alone PDP premium revenues increased $73.9 million, or 14.6%, during the 2011 quarter compared to the 2010 quarter and increased $224.9 million, or 14.9%, during the 2011 period compared to the 2010 period. These increases primarily were due to a 44.9% and 39.2% increase in average individual PDP membership for the 2011 quarter and period, respectively, compared to the 2010 quarter and period, partially offset by decreases in individual Medicare stand-alone PDP per member premiums for the same periods. This was primarily a result of sales of our low-price-point Humana Walmart-Preferred Rx Plan that we began offering for the 2011 plan year.

Benefit expenses

The Retail segment benefit ratio decreased 230 basis points from 81.0% in the 2010 quarter to 78.7% in the 2011 quarter. For the 2011 period, the Retail segment benefit ratio decreased 20 basis points to 81.9% from 82.1% for the 2010 period. The declines primarily reflect a lower Medicare Advantage benefit ratio due to lower cost trends arising out of our cost-reduction and outcome-enhancing strategies, including care coordination and disease management, as well as a significant increase in our individual Medicare stand-alone PDP membership in the 2011 quarter and period, partially offset by lower favorable prior-period medical claims reserve development in the 2011 quarter and period than in the 2010 quarter and period, respectively. As discussed previously, the individual Medicare stand-alone PDP product design carries a higher benefit ratio in the first quarter and the benefit ratio generally decreases as the year progresses. Favorable reserve development decreased the Retail segment benefit ratio by approximately 60 basis points and 70 basis points in the 2011 quarter and period, respectively, versus approximately 130 basis points and 120 basis points in the 2010 quarter and period, respectively.

Operating costs

The Retail segment operating cost ratio of 11.2% for the 2011 quarter increased 160 basis points from 9.6% for the 2010 quarter primarily reflecting increased expenses associated with the Medicare sales season for 2012 offerings which began a month earlier than in the prior year as well as a higher percentage of membership in individual Medicare stand-alone PDP products in light of the Humana Walmart-Preferred Rx Plan, first offered in 2011, which carry a higher operating cost ratio than other

Table of Contents

Medicare products. The Retail segment operating cost ratio of 10.1% for the 2011 period decreased 40 basis points from 10.5% for the 2010 period. The $147.5 million write-down of deferred acquisition costs in the 2010 period increased the operating cost ratio 100 basis points for the 2010 period. Excluding the impact of the write-down of deferred acquisition costs, the increase in the operating cost ratio year-over-year primarily reflects the same factors impacting the quarter-over-quarter comparisons.

Employer Group Segment

	September 30,		Change	
	2011	2010	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,181,300	1,257,900	(76,600)	(6.1)%
ASO	1,287,000	1,460,300	(173,300)	(11.9)%
Group Medicare Advantage	287,900	274,200	13,700	5.0%
Group Medicare Advantage ASO	27,600	28,400	(800)	(2.8)%
Total group Medicare Advantage	315,500	302,600	12,900	4.3%
Group Medicare stand-alone PDP	4,200	2,400	1,800	75.0%
Total group Medicare	319,700	305,000	14,700	4.8%
Total group medical members	2,788,000	3,023,200	(235,200)	(7.8)%
Group specialty membership(a)	6,419,300	6,502,700	(83,400)	(1.3)%

(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.

	For the three months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(in thousands)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 1,185,285	$ 1,275,945	$ (90,660)	(7.1)%
Group Medicare Advantage	802,957	723,378	79,579	11.0%
Group Medicare stand-alone PDP	1,910	1,153	757	65.7%
Total group Medicare	804,867	724,531	80,336	11.1%
Group specialty	235,050	216,814	18,236	8.4%
Total premiums	2,225,202	2,217,290	7,912	0.4%
Services	88,699	94,884	(6,185)	(6.5)%
Total premiums and services revenue	$ 2,313,901	$ 2,312,174	$ 1,727	0.1%
Income before income taxes	$ 45,857	$ 78,990	$ (33,133)	(41.9)%
Benefit ratio	83.5%	82.0%		1.5%
Operating cost ratio	17.5%	17.6%		(0.1)%

38

Table of Contents

	For the nine months ended September 30,		Change	
	2011	2010	Dollars	Percentage
		(in thousands)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 3,600,476	$ 3,904,705	$ (304,229)	(7.8)%
Group Medicare Advantage	2,364,306	2,259,733	104,573	4.6%
Group Medicare stand-alone PDP	5,638	3,443	2,195	63.8%
Total group Medicare	2,369,944	2,263,176	106,768	4.7%
Group specialty	697,934	663,055	34,879	5.3%
Total premiums	6,668,354	6,830,936	(162,582)	(2.4)%
Services	267,902	294,241	(26,339)	(9.0)%
Total premiums and services revenue	$ 6,936,256	$ 7,125,177	$ (188,921)	(2.7)%
Income before income taxes	$ 293,021	$ 260,223	$ 32,798	12.6%
Benefit ratio	81.1%	81.8%		(0.7)%
Operating cost ratio	17.5%	17.5%		0.0%

Pretax Results

Employer Group segment pretax income decreased $33.1 million, or 41.9%, from the 2010 quarter to $45.9 million in the 2011 quarter primarily due to a higher benefit ratio in the 2011 quarter as compared to the 2010 quarter. Employer Group segment pretax income increased $32.8 million, or 12.6%, from the 2010 period to $293.0 million for the 2011 period primarily due to a shift to a more profitable mix of membership. The Employer Group segment s pretax income for the 2011 quarter and period included the beneficial effect of an estimated $9 million and $42 million, respectively, in favorable prior-period medical claims reserve development versus $21 million and $29 million in the 2010 quarter and period, respectively.

Enrollment

Fully-insured commercial group medical membership decreased 76,600 members, or 6.1%, from September 30, 2010 to September 30, 2011 primarily due to continued pricing discipline in a highly competitive environment for large group business partially offset by small group business membership gains.

Group ASO commercial medical membership decreased 173,300 members, or 11.9%, from September 30, 2010 to September 30, 2011 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts.

Group specialty membership decreased 83,400 members, or 1.3%, from September 30, 2010 to September 30, 2011 primarily due to the loss of dental ASO membership, partially offset by increased sales of vision and other supplemental benefit offerings.

Premiums

Employer Group segment premiums increased $7.9 million, or 0.4%, to $2.2 billion for the 2011 quarter, primarily due to an increase in fully-insured group Medicare Advantage membership, partially offset by lower average commercial group medical membership. For the 2011 period, Employer Group segment premiums decreased by $162.6 million, or 2.4%, from the 2010 period to $6.7 billion primarily due to lower average commercial group medical membership year-over-year, partially offset by an increase in group

Medicare Advantage membership.

Table of Contents

Benefit expenses

The Employer Group segment benefit ratio of 83.5% for the 2011 quarter increased 150 basis points from 82.0% for the 2010 quarter, primarily reflecting lower favorable prior-period medical claims reserve development in the 2011 quarter versus the 2010 quarter, growth in our group Medicare Advantage products which generally carry a higher benefit ratio than our fully-insured commercial group products, and the effect of rebates accrued in the 2011 quarter associated with the minimum benefit ratios required under the Health Insurance Reform Legislation. The Employer Group segment benefit ratio decreased 70 basis points from 81.8% in the 2010 period to 81.1% in the 2011 period primarily due to lower utilization of benefits year-over-year in our commercial group products. Favorable reserve development decreased the Employer Group segment benefit ratio by approximately 30 basis points and 60 basis points in the 2011 quarter and period, respectively, versus 100 basis points and 40 basis points in the 2010 quarter and period, respectively.

Operating costs

The Employer Group segment operating cost ratio of 17.5% for the 2011 quarter decreased 10 basis points from 17.6% for the 2010 quarter primarily reflecting administrative scale efficiencies associated with an increase in average fully-insured group Medicare Advantage membership. The Employer Group segment operating cost ratio of 17.5% for the 2011 period was unchanged from the 2010 period.

Health and Well-Being Services Segment

	For the three months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(in thousands)			
Revenues:				
Services:				
Primary care services	$ 230,497	$ 401	$ 230,096	nm
Integrated wellness services	3,111	3,414	(303)	(8.9)%
Pharmacy solutions	2,864	0	2,864	100.0%
Total services revenues	236,472	3,815	232,657	nm
Intersegment revenues:				
Pharmacy solutions	2,481,322	2,079,329	401,993	19.3%
Primary care services	46,533	56,345	(9,812)	(17.4)%
Integrated wellness services	42,369	40,925	1,444	3.5%
Home care services	20,904	9,413	11,491	122.1%
Total intersegment revenues	2,591,128	2,186,012	405,116	18.5%
Total services and intersegment revenues	$ 2,827,600	$ 2,189,827	$ 637,773	29.1%
Income before income taxes	$ 83,565	$ 75,537	$ 8,028	10.6%
Operating cost ratio	96.3%	96.2%		0.1%

Table of Contents

	For the nine months ended September 30,		Change	
	2011	2010	Dollars	Percentage
	(in thousands)			
Revenues:				
Services:				
Primary care services	$ 661,995	$ 1,309	$ 660,686	nm
Integrated wellness services	9,060	8,560	500	5.8%
Pharmacy solutions	7,683	0	7,683	100.0%
Total services revenues	678,738	9,869	668,869	nm
Intersegment revenues:				
Pharmacy solutions	7,338,878	6,336,725	1,002,153	15.8%
Primary care services	133,957	125,427	8,530	6.8%
Integrated wellness services	126,050	124,834	1,216	1.0%
Home care services	55,829	24,652	31,177	126.5%
Total intersegment revenues	7,654,714	6,611,638	1,043,076	15.8%
Total services and intersegment revenues	$ 8,333,452	$ 6,621,507	$ 1,711,945	25.9%
Income before income taxes	$ 267,741	$ 174,637	$ 93,104	53.3%
Operating cost ratio	96.1%	97.1%		(1.0)%

nm not meaningful

Pretax results

Health and Well-Being Services segment pretax income increased $8.0 million, or 10.6%, from the 2010 quarter to $83.6 million for the 2011 quarter. The segment s pretax income for the 2011 period increased $93.1 million, or 53.3%, from the 2010 period to $267.7 million. The 2010 quarter was favorably impacted by a $22.3 million risk share adjustment to intersegment revenues associated with our CAC medical centers in connection with the Medicare risk adjustment settlement. Excluding the impact of the CAC medical centers adjustment, the increases in our quarterly and year-to-date comparisons primarily were due to growth in our pharmacy solutions business together with the addition of the Concentra business, acquired on December 21, 2010.

Services revenue

Primary care services revenue increased $230.1 million and $660.7 million from the 2010 quarter and period, respectively, to $230.5 million and $662.0 million for the 2011 quarter and period, respectively, primarily due to the acquisition of Concentra on December 21, 2010.

Intersegment revenues

Intersegment revenues increased $405.1 million, or 18.5%, from the 2010 quarter to $2.6 billion for the 2011 quarter and increased $1.0 billion, or 15.8%, from the 2010 period to $7.7 billion for the 2011 period. The increases primarily were due to growth in our pharmacy solutions business as it serves our growing membership, particularly Medicare stand-alone PDP.

Operating costs

The Health and Well-Being Services segment operating cost ratio of 96.3% for the 2011 quarter increased 10 basis points from the 2010 quarter. The CAC medical centers adjustment discussed above reduced the operating cost ratio 100 basis points in the 2010 quarter. The operating cost ratio for the 2011 period was 96.1%, decreasing 100 basis points from the 2010 period. Excluding the impact of the CAC medical centers adjustment, the decreases in our quarterly and year-to-date comparisons primarily reflect scale efficiencies associated with growth in our pharmacy solutions business together with the addition of our acquired Concentra operations which carry a lower operating cost ratio than other lines of business in this segment.

Table of Contents

Other Businesses

Pretax income for our Other Businesses of $27.7 million for the 2011 quarter compares to $22.0 million for the 2010 quarter. Pretax income for our Other Businesses for the 2011 period of $82.3 million decreased $26.1 million from the 2010 period primarily due to a decrease in pretax income associated with our contract with CMS to administer the Limited Income Newly Eligible Transition (LI-NET) program.

Liquidity

Our primary sources of cash include receipts of premiums, service revenues, and investment and other income, as well as proceeds from the sale or maturity of our investment securities and borrowings. Our primary uses of cash include 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. The use of operating cash flows may be limited by regulatory requirements which require, among other items, that our regulated subsidiaries maintain minimum levels of capital.

For additional information on our liquidity risk, please refer to the section entitled Risk Factors in this report and in our 2010 Form 10-K.

Cash and cash equivalents increased to $4,019.4 million at September 30, 2011 from $1,673.1 million at December 31, 2010. The change in cash and cash equivalents for the nine months ended September 30, 2011 and 2010 is summarized as follows:

	2011	2010
	(in thousands)	
Net cash provided by operating activities	$ 3,875,980	$ 2,289,171
Net cash used in investing activities	(1,143,197)	(865,070)
Net cash used in financing activities	(386,515)	(114,837)
Increase in cash and cash equivalents	$ 2,346,268	$ 1,309,264

Cash Flow from Operating Activities

Our operating cash flows for the 2011 period were significantly impacted by the early receipt of the Medicare premium remittance for October 2011 of $1,795.6 million in September 2011 because the payment date of October 1, 2011 fell on a weekend. Generally, when the first day of a month falls on a weekend or holiday, with the exception of January 1 (New Year s Day), we receive this payment at the end of the previous month. Therefore, the 2011 period included ten monthly Medicare payments compared to only nine monthly Medicare payments during the 2010 period. This also resulted in an increase to unearned revenues in our condensed consolidated balance sheet at September 30, 2011.

Excluding the impact from the timing of the Medicare premium receipt, the decrease in operating cash flows from the 2010 period to the 2011 period primarily results from the timing of other working capital items, partially offset by an increase in earnings.

Comparisons of our operating cash flows are impacted by changes in our working capital. The most significant drivers of changes in our working capital are typically the timing of receipts for premiums and payments of benefit expenses. We illustrate these changes with the following summaries of receivables and benefits payable.

Table of Contents

The detail of total net receivables was as follows at September 30, 2011 and December 31, 2010:

	September 30, 2011	December 31, 2010	2011 Period Change	2010 Period Change
		(in thousands)		
Military services:				
Base receivables	$ 531,894	$ 424,786	$ 107,108	$ 4,385
Change orders	497	2,052	(1,555)	(248)
Military services subtotal	532,391	426,838	105,553	4,137
Medicare	183,879	216,080	(32,201)	(66,721)
Commercial and other	405,062	367,570	37,492	50,337
Allowance for doubtful accounts	(85,015)	(51,470)	(33,545)	(3,345)
Total net receivables	$ 1,036,317	$ 959,018	$ 77,299	$ (15,592)

Military services base receivables consist of estimated claims owed from the federal government for health care services provided to beneficiaries and underwriting fees. The claim reimbursement component of military services base receivables is generally collected over a three to four month period. The timing of claim reimbursements resulted in the $107.1 million increase in base receivables from December 31, 2010 to September 30, 2011 and the $4.4 million increase in base receivables from December 31, 2009 to September 30, 2010.

Medicare receivables decreased $32.2 million from December 31, 2010 to September 30, 2011 and decreased $66.7 million from December 31, 2009 to September 30, 2010. Medicare receivables are impacted by the timing of accruals and related collections associated with the CMS risk-adjustment model.

Commercial and other receivables increased $37.5 million and the allowance for doubtful accounts increased $33.5 million from December 31, 2010 to September 30, 2011 primarily due to the Concentra acquisition. The $50.3 million increase in commercial and other receivables from December 31, 2009 to September 30, 2010 primarily resulted from the timing of reimbursements from the Puerto Rico Health Insurance Administration for our Medicaid business.

The detail of benefits payable was as follows at September 30, 2011 and December 31, 2010:

	September 30, 2011	December 31, 2010	2011 Period Change	2010 Period Change
		(in thousands)		
IBNR(1)	$ 2,131,410	$ 2,051,227	$ 80,183	$ 220,769
Military services benefits payable(2)	375,865	255,180	120,685	36,271
Reported claims in process(3)	331,045	136,803	194,242	226
Other benefits payable(4)	1,030,108	1,026,096	4,012	247,071
Total benefits payable	$ 3,868,428	$ 3,469,306	$ 399,122	$ 504,337

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date. 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) Military services benefits payable primarily results from the timing of the cost of providing health care services to beneficiaries and the payment to the provider. A corresponding receivable for reimbursement by the federal government is included in the base receivable in the previous receivables table.

(3)

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.

(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increase in benefits payable from December 31, 2010 to September 30, 2011 primarily was due to an increase in amounts due to our pharmacy benefit administrator which fluctuate due to month-end cutoff, an increase in Military services benefits payable, and an increase in IBNR as a result of Medicare Advantage membership

Table of Contents

growth. The increase in benefits payable from December 31, 2009 to September 30, 2010 primarily was due to an increase in IBNR as well as an increase in amounts owed to providers under capitated and risk sharing arrangements, both primarily as a result of Medicare Advantage membership growth.

In addition to the timing of receipts for premiums and ASO fees and payments of benefit expenses, other working capital items impacting operating cash flows primarily resulted from the timing of payments for the Medicare Part D risk corridor provisions of our contracts with CMS. Payment under the risk corridor provisions is made in the fourth quarter of each year.

Cash Flow from Investing Activities

We reinvested a portion of our operating cash flows in investment securities, primarily fixed income securities, totaling $957.8 million in the 2011 period and $790.8 million in the 2010 period. Our ongoing capital expenditures primarily relate to our information technology initiatives and administrative facilities necessary for activities such as claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service as well as patient services in our Concentra medical centers. Total capital expenditures, excluding acquisitions, were $215.9 million in the 2011 period compared to $152.4 million in the 2010 period. Excluding acquisitions, we expect total capital expenditures in 2011 of approximately $305 million versus $222 million for the full year 2010, primarily due to increased capital expenditures associated with growth in our pharmacy and primary care services businesses in our Health and Well-Being Services segment.

Cash Flow from Financing Activities

Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were $225.4 million higher than claims payments during the 2011 period and $202.2 million higher than claim payments during the 2010 period.

During the 2011 period, we repurchased 6.7 million shares for $491.5 million under the stock repurchase plans authorized by the Board of Directors in December 2009 and April 2011. During the 2010 period, we repurchased 1.99 million shares for $100.0 million under the stock repurchase plan authorized by the Board of Directors in December 2009. During the 2011 period, we also acquired 0.8 million common shares in connection with employee stock plans for an aggregate cost of $48.7 million compared to 0.2 million shares for an aggregate cost of $8.2 million in the 2010 period.

During the 2011 period, we paid dividends to stockholders of $41.5 million as discussed further below. No dividends were paid during 2010.

The remainder of the cash used in or provided by financing activities in the 2011 and 2010 periods primarily resulted from the change in the book overdraft and proceeds from stock option exercises.

Future Sources and Uses of Liquidity

Dividends

In April 2011, our Board of Directors approved the initiation of a quarterly cash dividend policy. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of our dividend payments in 2011:

Record Date	Payment Date	Amount per Share	Total Amount (in millions)
6/30/2011	7/28/2011	$ 0.25	$ 41.5
9/30/2011	10/28/2011	$ 0.25	$ 40.7

In addition, in October 2011, our Board of Directors declared a cash dividend to stockholders of $0.25 per share payable on January 31, 2012 to stockholders of record on December 30, 2011.

44

Table of Contents

Stock Repurchase Authorization

In April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion of our common shares exclusive of shares repurchased in connection with employee stock plans. The new authorization will expire June 30, 2013. Under this share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions, subject to certain regulatory restrictions on volume, pricing, and timing. As of October 31, 2011, the remaining authorized amount under the new authorization totaled $561.3 million.

Senior Notes

We previously issued $500 million of 6.45% senior notes due June 1, 2016, $500 million of 7.20% senior notes due June 15, 2018, $300 million of 6.30% senior notes due August 1, 2018, and $250 million of 8.15% senior notes due June 15, 2038. 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) and contain a change of control provision that may require us to purchase the notes under certain circumstances. All four series of 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.

Credit Agreement

Our 3-year $1.0 billion unsecured revolving agreement expires December 2013. 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 or the base rate plus a spread. The spread, currently 170 basis points, varies depending on our credit ratings ranging from 150 to 262.5 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 30 basis points, may fluctuate between 25 and 62.5 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 event 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 $5,868.0 million at September 30, 2011 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $7,858.0 million and a leverage ratio of 0.6:1, as measured in accordance with the credit agreement as of September 30, 2011. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At September 30, 2011, we had no borrowings outstanding under the credit agreement. We have outstanding letters of credit of $11.6 million secured under the credit agreement. No amounts have ever been drawn on these letters of credit. Accordingly, as of September 30, 2011, we had $988.4 million 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.

Other Long-Term Borrowings

Other long-term borrowings of $36.6 million at September 30, 2011 represent junior subordinated debt of $36.1 million and financing for the renovation of a building of $0.5 million. The junior subordinated debt, which is due in 2037, may be called by us without penalty in 2012 and bears a fixed annual interest rate of 8.02% payable quarterly until 2012, and then payable at a floating rate based on LIBOR plus 310 basis points. The debt associated with the building renovation bears interest at 2.00%, is collateralized by the building, and is payable in various installments through 2014.

Table of Contents

Liquidity Requirements

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, 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 September 30, 2011 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 $1.9 million, up to a maximum 100 basis points, or annual interest expense by $7.5 million.

In addition, we operate as a holding company in a highly regulated industry. The parent company is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. Dividends to our parent company from our operating subsidiaries were approximately $1.1 billion in the 2011 period compared to approximately $747 million in 2010. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries.

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, 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 can vary significantly at the state level. Based on the most recently filed statutory financial statements as of June 30, 2011, our state regulated subsidiaries had aggregate statutory capital and surplus of approximately $4.1 billion, which exceeded aggregate minimum regulatory requirements.

Table of Contents

Item 3. Quantitative and Qualitative Disclosure about Market Risk

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

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 September 30, 2011. Our net unrealized gain position increased $251.1 million from a net unrealized gain position of $196.5 million at December 31, 2010 to a net unrealized gain position of $447.6 million at September 30, 2011. At September 30, 2011, we had gross unrealized losses of $35.8 million on our investment portfolio primarily due to an increase in market interest rates and tighter liquidity conditions in the current markets than when the securities were purchased, and as such, there were no material other-than-temporary impairments during the three and nine months ended September 30, 2011. 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 3.1 years as of September 30, 2011. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $418 million.

Item 4. Controls and Procedures

Under the supervision and with the participation of our Chief Executive Officer, or CEO, our Chief Financial Officer, or CFO, and our Principal Accounting Officer, we carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures for the quarter ended September 30, 2011.

Based on our evaluation, our CEO, CFO, and Principal Accounting Officer concluded that our disclosure controls and procedures are effective to provide reasonable assurance that information the Company is required to disclose in its reports under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported within the time periods specified in SEC rules and forms, including, without limitation, ensuring that such information is accumulated and communicated to the Company s management, including its principal executive and principal financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure.

There have been no changes in the Company s internal control over financial reporting during the quarter ended September 30, 2011 that have materially affected, or are reasonably likely to materially affect, the Company s internal control over financial reporting.

Table of Contents

Part II. Other Information

Item 1. Legal Proceedings

For a description of the legal proceedings pending against us, see Legal Proceedings and Certain Regulatory Matters in Note 12 to the condensed consolidated financial statements beginning on page 19 of this Form 10-Q.

Item 1A. Risk Factors

Except as set forth below, there have been no changes to the risk factors included in our 2010 Form 10-K, as modified by the changes to those risk factors included in other reports we filed with the SEC subsequent to February 17, 2011:

On February 25, 2011, the Department of Defense TRICARE Management Activity, or TMA, awarded the TRICARE South Region contract to us. On March 7, 2011, the competing bidder filed a protest of the award with the Government Accountability Office, or GAO. Also on March 7, 2011, as provided in the Federal Acquisition Regulations, TMA issued a stop work order to us in connection with the award. On June 14, 2011, the GAO upheld the award of the contract to us and TMA subsequently lifted the stop work order. On June 21, 2011, the competing bidder filed a complaint in the United States Court of Federal Claims objecting to the award of the contract to us. On October 14, 2011, the Court upheld the award of the contract to us, and the competing bidder has until December 13, 2011 to appeal it in the Court of Appeals for the Federal Circuit. As a result of the award of the TRICARE South Region contract to us, we no longer expect a goodwill impairment to occur during the second half of 2011. Ultimate disposition of the contract award is, however, subject to the resolution of any additional actions the unsuccessful bidder may take.

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 77% of our total premiums and services revenue for the nine months ended September 30, 2011. These programs involve various risks, as described in our 2010 Form 10-K and supplemented as follows:

The Budget Control Act of 2011, enacted on August 2, 2011, increased the United States debt ceiling in connection with deficit reductions over the next ten years. The Budget Control Act of 2011 also establishes a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. Reductions in Medicare and Medicaid spending could be included as part of these deficit reduction measures. Moreover, if such legislation is not enacted by December 23, 2011, approximately $1.2 trillion in domestic and defense spending reductions will automatically begin January 1, 2013, split evenly between domestic and defense spending. Payments to Medicare providers would be subject to these automatic spending reductions, subject to a 2% cap. At this time it is unclear how this automatic reduction may be applied to various Medicare healthcare programs. We expect that if such reductions were to occur, there would be a corresponding substantial reduction in our obligations to providers, however there can be no assurances that this would completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.

This list of important factors is not intended to be exhaustive, and should be read in conjunction with the more detailed description of these risks that may be found in our reports filed with the SEC from time to time, including our annual report on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K.

Table of Contents

Item 2: Unregistered Sales of Equity Securities and Use of Proceeds

(a) None.

(b) N/A

(c) The following table provides information about purchases by us during the three months ended September 30, 2011 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)
July 2011	0	$ 0	0	$ 799,947,644
August 2011	3,381,216	70.62	3,381,216	561,274,880
September 2011	0	0	0	561,274,880
Total	3,381,216	$ 70.62	3,381,216	$ 561,274,880

(1) As announced on April 26, 2011, in April 2011, the Board of Directors replaced its previously approved share repurchase authorization of up to $250 million with a new authorization for repurchases of up to $1 billion of our common shares exclusive of shares repurchased in connection with employee stock plans. The new authorization will expire June 30, 2013. Under this share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions, subject to certain regulatory restrictions on volume, pricing, and timing. As of October 31, 2011, the remaining authorized amount under the new authorization totaled $561.3 million.

(2) Excludes 9,364 shares repurchased in connection with employee stock plans.

Item 3: Defaults Upon Senior Securities

None.

Item 4: Removed and Reserved

None.

Item 5: Other Information

None.

Table of Contents

Item 6: Exhibits

3(i)	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).
3(ii)	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).
12	Computation of ratio of earnings to fixed charges.
31.1	Principal Executive Officer certification pursuant to Section 302 of Sarbanes Oxley Act of 2002.
31.2	Principal Financial Officer certification pursuant to Section 302 of Sarbanes Oxley Act of 2002.
32	Principal Executive Officer and Principal Financial Officer certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS**	XBRL Instance Document
101.SCH**	XBRL Taxonomy Extension Schema Document
101.CAL**	XBRL Taxonomy Calculation Linkbase Document
101.DEF**	XBRL Taxonomy Definition Linkbase Document
101.LAB**	XBRL Taxonomy Label Linkbase Document
101.PRE**	XBRL Taxonomy Presentation Linkbase Document

** Submitted electronically with this report.
Attached as Exhibit 101 to this report are the following documents formatted in XBRL (Extensible Business Reporting Language): (i) the Condensed Consolidated Balance Sheets at September 30, 2011 and December 31, 2010; (ii) the Condensed Consolidated Statements of Income for the three and nine months ended September 30, 2011 and September 30, 2010, respectively; (iii) the Condensed Consolidated Statements of Cash Flows for the nine months ended September 30, 2011 and September 30, 2010, respectively; and (iv) Notes to Condensed Consolidated Financial Statements.

Table of Contents

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

HUMANA INC.
(Registrant)

Date: October 31, 2011

By: /s/ JAMES H. BLOEM
James H. Bloem

Senior Vice President, Chief Financial Officer and Treasurer

(Principal Financial Officer)

Date: October 31, 2011

By: /s/ STEVEN E. MCCULLEY
Steven E. McCulley

Vice President and Controller

(Principal Accounting Officer)