HUMANA INC
Form 10-K
February 16, 2018
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, 2017
OR
¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number 1-5975
HUMANA INC.
(Exact name of registrant as specified in its charter)

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

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

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

Securities registered pursuant to Section 12(g) of the Act: None
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes 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, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):
Large accelerated filer þ Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨
Emerging growth company ¨
If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards pursuant to Section 13(a) of the Exchange Act. ¨
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No þ

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2017 was $34,733,751,307 calculated using the average price on June 30, 2017 of $240.77.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2018 was 137,684,326.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 19, 2018.

HUMANA INC.
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For the Year Ended December 31, 2017

Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

As of December 31, 2017, we had approximately 14 million members in our medical benefit plans, as well as approximately 7 million members in our specialty products. During 2017, 79% of our total premiums and services revenue were derived from contracts with the federal government, including 15% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 609,600 members as of December 31, 2017.

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

This Annual Report on Form 10-K, or 2017 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2017 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as

Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. On February 14, 2017, we and Aetna agreed to mutually terminate the July 2, 2015 Agreement and Plan of Merger as more fully discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Health Care Reform Law, enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year industry wide commercial reinsurance fee. The Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform" in this 2017 Form 10-K.

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

Business Segments

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

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

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require

the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2017:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 32,720	61.3 %
Group Medicare Advantage	5,155	9.7 %
Medicare stand-alone PDP	3,702	6.9 %
Total Retail Medicare	41,577	77.9 %
State-based Medicaid	2,571	4.8 %
Medicare Supplement	478	0.9 %
Total premiums	44,626	83.6 %
Services	10	— %
Total premiums and services revenue	$ 44,636	83.6 %

Medicare

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

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

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

Individual Medicare Advantage Products

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

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

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

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS.

At December 31, 2017, we provided health insurance coverage under CMS contracts to approximately 2,860,800 individual Medicare Advantage members, including approximately 609,600 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.8 billion, which represented approximately 23.8% of

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our individual Medicare Advantage premiums revenue, or 14.6% of our consolidated premiums and services revenue for the year ended December 31, 2017.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2018, and all of our product offerings filed with CMS for 2018 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, titled “Medicare Part D.” Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2018, and all of our product offerings filed with CMS for 2018 have been approved.

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

Group Medicare Advantage and Medicare stand-alone PDP

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

State-based Medicaid Contracts

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

We have contracts to serve Medicaid eligible members in Florida and Kentucky under the TANF program, as well as contracts in Florida under the LTSS program. Our Kentucky Medicaid contract is subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and

Medicare costs. There were approximately 10.7 million dual eligible individuals in the United States in 2017, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and LTSS benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs. We previously had an Integrated Care Program, or ICP, Medicaid contract in Illinois and a stand-alone dual eligible demonstration program in Virginia, both of which terminated on December 31, 2017. We continue to serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans.

Our Group and Specialty Segment Products

The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group and Specialty segment by product for the year ended December 31, 2017:

	Group and Specialty Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue	
	(dollars in millions)		
External Revenue:			
Premiums:			
Fully-insured commercial group	$ 5,462	10.2	%
Specialty	1,310	2.5	%
Total premiums	6,772	12.7	%
Services	626	1.2	%
Total premiums and services revenue	$ 7,398	13.9	%
Intersegment services revenue	$ 20	n/a	

n/a – not applicable

Group Commercial Coverage

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

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

Employers can customize their offerings with optional benefits such as dental, vision, life, and a portfolio of voluntary benefit products. We also offer optional benefits such as dental, vision life, and a portfolio of financial protection products to individuals.

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Military Services

Under our TRICARE contracts with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. Under our contracts, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. During 2017, we delivered services under the 5-year T3 South Region contract, which expired on December 31, 2017. On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The T2017 East contract is a 5-year contract set to expire on December 31, 2022 and is subject to renewals on January 1 of each year during its term at the government's option.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, clinical care services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2017:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$20,881	n/a
Provider services	1,593	n/a
Clinical care services	1,111	n/a
Total intersegment revenue	$23,585	
External services revenue:		
Pharmacy solutions	$80	0.2 %
Provider services	77	0.1 %
Clinical care services	181	0.3 %
Total external services revenue	$338	0.6 %

n/a – not applicable

Pharmacy solutions

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

Provider services

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

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

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

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

Clinical care services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Clinical care services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. At December 31, 2017, we have enrolled approximately 794,900 members with complex chronic conditions in a Humana Chronic Care Program, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

We have committed additional investments in our home care capabilities. On December 19, 2017, we announced that we had entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division of Kindred Healthcare Inc., the nation’s largest home health provider and second largest hospice operator.

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

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

Wellness

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

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

Our Individual Commercial Segment Products

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

We discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. We exited our remaining individual commercial medical business effective January 1, 2018 as more fully described in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Other Businesses

Other Businesses primarily includes our closed block of long-term care insurance policies described below. Total premiums and services revenue for our Other Businesses was $43 million, or 0.1% of consolidated premiums and services revenue for the year ended December 31, 2017.

We have a non-strategic closed block of approximately 29,800 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG’s subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care insurance policies. For a detailed discussion of the definitive agreement refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Membership

The following table summarizes our total medical membership at December 31, 2017, by market and product:

	Retail Segment (in thousands)					Group and Specialty Segment						
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Individual Commercial	Other Businesses	Total	Percent of Total
Florida	609.6	16.0	388.7	7.2	339.7	124.6	34.0	—	13.9	—	1,533.7	11.0 %
Texas	225.0	189.6	331.9	8.7	—	201.3	23.8	—	5.2	—	985.5	7.0 %
Kentucky	79.7	58.9	221.6	5.6	—	109.6	144.4	—	1.5	—	621.3	4.4 %
California	64.8	0.4	490.5	19.5	—	—	—	—	—	—	575.2	4.1 %
Ohio	119.3	20.3	194.9	47.7	—	50.6	51.2	—	1.2	—	485.2	3.5 %
Illinois	95.1	22.0	190.9	4.5	12.8	59.9	76.0	—	6.4	—	467.6	3.3 %
Georgia	113.9	1.8	135.9	10.5	—	163.7	27.6	—	1.7	—	455.1	3.3 %
Missouri/Kansas	81.7	5.0	228.0	8.5	—	51.3	10.3	—	14.0	—	398.8	2.9 %
Tennessee	146.1	3.9	119.2	4.4	—	42.3	10.1	—	57.6	—	383.6	2.7 %
Louisiana	158.5	11.6	61.3	1.9	—	69.0	9.8	—	19.8	—	331.9	2.4 %
North Carolina	142.4	0.4	184.5	0.7	—	—	—	—	—	—	328.0	2.3 %
Wisconsin	59.9	10.9	121.7	5.7	—	84.2	30.1	—	—	—	312.5	2.2 %
Virginia	116.6	2.6	158.3	8.6	7.6	—	—	—	—	—	293.7	2.1 %
Indiana	93.0	7.0	146.6	8.2	—	20.1	12.3	—	—	—	287.2	2.1 %
Michigan	49.1	12.5	150.3	3.0	—	3.7	0.4	—	4.9	—	223.9	1.6 %
Pennsylvania	42.8	0.6	166.1	4.6	—	—	—	—	—	—	214.1	1.5 %
Arizona	59.2	0.2	100.1	4.1	—	29.0	2.8	—	—	—	195.4	1.4 %
South Carolina	88.5	0.4	89.0	5.0	—	—	—	—	—	—	182.9	1.3 %
Military services	—	—	—	—	—	—	—	3,081.8	—	—	3,081.8	22.0 %
Others	515.6	77.3	1,828.6	77.5	—	88.4	25.9	—	2.6	29.8	2,645.7	18.9 %
Totals	2,860.8	441.4	5,308.1	235.9	360.1	1,097.7	458.7	3,081.8	128.8	29.8	14,003.1	100.0 %

Provider Arrangements

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

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

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

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

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

Capitation

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

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

At December 31, 2017, approximately 1,102,100 members, or 7.9% of our medical membership, were covered under risk-based contracts, including 903,500 individual Medicare Advantage members, or 31.6% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician’s financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 170,700 HMO members, including 155,500 individual Medicare Advantage members, or 17.2% of the 903,500 individual Medicare Advantage members covered under risk-based contracts at December 31, 2017, with the provider assuming substantially all the risk of coordinating the members’ health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.4 billion, or 3.2% of total benefits expense, for the year ended December 31, 2017. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

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

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

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

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

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

Sales and Marketing

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

At December 31, 2017, we employed approximately 1,600 sales representatives, as well as approximately 1,300 telemarketing representatives who assisted in the marketing of Medicare in our Retail segment, individual commercial health insurance in our Individual Commercial segment, and specialty products in our Group and Specialty segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group and Specialty segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer’s or group’s exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs

and expectations of their employees or members. In addition, we offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange where employees can shop for a health plan and other benefits based on what the employer has selected as options. We use licensed independent brokers, independent agents, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our individual commercial health insurance and specialty products.

Underwriting

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

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2017 Form 10-K.

Government Regulation

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

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

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2017 Form 10-K.

Certain Other Services

Captive Insurance Company

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

Centralized Management Services

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

Employees

As of December 31, 2017, we had approximately 45,900 employees and approximately 2,000 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to Certain Proposed Transactions

Certain proposed transactions, including the divestiture of our subsidiary, KMG, and the acquisition of a minority interest in Kindred Healthcare, Inc.'s Kindred at Home division, are subject to various closing conditions, including various regulatory approvals and customary closing conditions, as well as other uncertainties, and there can be no assurances as to whether and when it may be completed.

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies that serves approximately 29,800 policyholders. On December 19, 2017, we announced that we had entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home division of Kindred Healthcare, Inc. Consummation of each of these transactions involves certain risks, including, among other things, the timing to consummate the transaction, the risk that a condition to closing of the transaction may not be satisfied, the risk that required regulatory approvals for the transaction are not obtained, are delayed or are subject to conditions that are not anticipated, the risk that we may not recognize all or a portion of the expected benefits from either or both transactions, including tax benefits and expected synergies, and the risk of indemnification exposure under the contractual agreements to effect the transactions.

Risks Relating to Our Business

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

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

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;

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

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

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

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

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

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

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

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract. If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives and our state-based contracts strategy, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products. In addition, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years.

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 78% of our total premiums and services revenue for the year ended December 31, 2017 generated from our Medicare products, including 15% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

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

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

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

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

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

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

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

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

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause

shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

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

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

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

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

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

- professional liability claims arising out of the delivery of healthcare and related services to the public.

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

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

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

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

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

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 84% of our total premiums and services revenue for the year ended December 31, 2017. These programs involve various risks, as described further below.

- At December 31, 2017, under our contracts with CMS we provided health insurance coverage to approximately 609,600 individual Medicare Advantage members in Florida. These contracts accounted for approximately 15% of our total premiums and services revenue for the year ended December 31, 2017. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2017, primarily consisted of the T3 TRICARE South Region contract. The 5-year T3 South Region contract expired on December 31, 2017. On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East

- Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The loss of the TRICARE T2017 East Region contract may have a material adverse effect on our results of operations, financial position, and cash flows.

There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government

- contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government

does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.

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

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

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

In 2012, CMS released a “Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits.” The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the RADV audit sample will be extrapolated to the entire MA contract after a comparison of the audit results to a similar audit of Medicare FFS (we refer to the process of accounting for errors in FFS claims as the "FFS Adjuster"). This comparison of RADV audit results to the FFS error rate is necessary to determine the economic impact, if any, of RADV audit results because the government used the Medicare FFS program data set, including any attendant errors that are present in that data set, to estimate the costs of various health status conditions and to set the resulting adjustments to MA plans’ payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the Medicare FFS program dataset).

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract

year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013 in which two, five and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited.

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

In addition, as part of our internal compliance efforts, we routinely perform ordinary course reviews of our internal business processes related to, among other things, our risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, these ordinary course reviews may have a material adverse effect on our results of operations, financial position, or cash flows.

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

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

The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a “risk corridor”). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $279 million and $150 million at December 31, 2017 and 2016, respectively.

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

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

We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

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

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). Financing for these reforms come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to

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repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

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

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

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

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

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

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

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act and HIPAA mandate individual notification in the event of a breach of unsecured, individually identifiable health information, provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

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

American Recovery and Reinvestment Act of 2009 (ARRA)

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

associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires HHS to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

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

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

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

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

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

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure

our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

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

State Regulation of Insurance-Related Products

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

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

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

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

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

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

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

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

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

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The U.S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

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

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

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it

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has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

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

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

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

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

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

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

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

request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

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

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

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

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

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2017:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	147	—	68	226
Texas	—	19	2	15	36
Kentucky	2	1	11	10	24
Arizona	—	12	—	6	18
Louisiana	—	5	—	11	16
Virginia	—	9	—	7	16
California	—	—	2	13	15
South Carolina	—	6	4	5	15
Illinois	—	5	—	8	13
New York	—	—	—	13	13
Ohio	—	1	—	11	12
Indiana	—	4	—	7	11
Nevada	—	7	—	4	11
Puerto Rico	—	—	—	11	11
Tennessee	—	—	—	8	8
Colorado	—	5	—	3	8
Georgia	—	5	—	3	8
New Jersey	—	—	—	8	8
Michigan	—	5	—	3	8
Washington	—	4	—	3	7
North Carolina	—	2	—	5	7
Others	—	7	1	37	45
Total	13	244	20	259	536

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of the medical centers included in the table above, approximately 68 of these facilities are leased or subleased to our contracted providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

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

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2017 and 2016:

	High	Low
Year Ended December 31, 2017		
First quarter	$219.25	$195.24
Second quarter	$240.62	$209.77
Third quarter	$258.75	$230.77
Fourth quarter	$260.86	$233.28
Year Ended December 31, 2016		
First quarter	$186.91	$156.96
Second quarter	$190.07	$165.23
Third quarter	$180.86	$153.38
Fourth quarter	$216.76	$165.31

Holders of our Capital Stock

As of January 31, 2018, there were approximately 2,500 holders of record of our common stock and approximately 94,900 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2016 and 2017, under our Board approved quarterly cash dividend policy:

Record Date	Payment Date	Amount per Share	Total Amount (in millions)
2016 payments			
12/30/2015	1/29/2016	$0.29	$43
3/31/2016	4/29/2016	$0.29	$43
6/30/2016	7/29/2016	$0.29	$43
10/13/2016	10/28/2016	$0.29	$43
2017 payments			
1/12/2017	1/27/2017	$0.29	$43
3/31/2017	4/28/2017	$0.40	$58
6/30/2017	7/31/2017	$0.40	$58
9/29/2017	10/27/2017	$0.40	$57

On November 2, 2017, the Board declared a cash dividend of $0.40 per share that was paid on January 26, 2018 to stockholders of record on December 29, 2017, for an aggregate amount of $55 million.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2017. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2012, and that dividends were reinvested when paid.

	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017
HUM	$ 100	$ 152	$ 214	$ 267	$ 307	$ 377
S&P 500	$ 100	$ 132	$ 150	$ 153	$ 171	$ 208
Peer Group	$ 100	$ 137	$ 175	$ 186	$ 188	$ 238

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

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2017 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1) (2)
October 2017	916,505	$ 244.44	916,505	$ 286,200,345
November 2017	846,752	244.54	846,752	79,136,387
December 2017	3,595,536	244.51	3,595,536	2,200,000,000
Total	5,358,793	$ 244.50	5,358,793	

(1) On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. We repurchased shares under an accelerated stock repurchase agreement and in the open market, utilizing the $2.25 billion authorization prior to expiration.

On December 14, 2017, our Board of Directors authorized the repurchase of up to $3.0 billion of our common shares expiring on December 31, 2020, exclusive of shares repurchased in connection with employee stock plans. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions, including pursuant to accelerated share repurchase agreements with investment banks, subject to certain regulatory restrictions on volume, pricing, and timing. On December 22, 2017, we announced that we had entered into an accelerated stock repurchase agreement, the December 2017 ASR, with Bank of America, N.A., or BofA, to repurchase $1.0 billion of our common stock as part of the $3.0 billion share repurchase program authorized on December 14, 2017. On December 22, 2017, we made a payment of $1.0 billion to BofA from available cash on hand and received an initial delivery of 3.28 million shares of our common stock from BofA based on the then current market price of Humana common stock. The payment to BofA was recorded as a reduction to stockholders' equity, consisting of an $800 million increase in treasury stock, which reflects the value of the initial 3.28 million shares received upon initial settlement, and a $200 million decrease in capital in excess of par value, which reflected the value of stock held back by BofA pending final settlement of the December 2017 ASR. Our remaining repurchase authorization was approximately $2.0 billion as of February 16, 2018, excluding the $200 million pending final settlement of our December 22, 2017 ASR.

(2) Excludes 0.14 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

	2017	2016 (a)	2015 (b)	2014	2013 (c)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$52,380	$53,021	$52,409	$45,959	$38,829
Services	982	969	1,406	2,164	2,109
Investment income	405	389	474	377	375
Total revenues	53,767	54,379	54,289	48,500	41,313
Operating expenses:					
Benefits	43,496	45,007	44,269	38,166	32,564
Operating costs	6,567	7,173	7,295	7,639	6,355
Merger termination fee and related costs, net	(936)	104	23	—	—
Depreciation and amortization	378	354	355	333	333
Total operating expenses	49,505	52,638	51,942	46,138	39,252
Income from operations	4,262	1,741	2,347	2,362	2,061
Gain on sale of business	—	—	270	—	—
Interest expense	242	189	186	192	140
Income before income taxes	4,020	1,552	2,431	2,170	1,921
Provision for income taxes	1,572	938	1,155	1,023	690
Net income	$2,448	$614	$1,276	$1,147	$1,231
Basic earnings per common share	$16.94	$4.11	$8.54	$7.44	$7.81
Diluted earnings per common share	$16.81	$4.07	$8.44	$7.36	$7.73
Dividends declared per common share	$1.60	$1.16	$1.15	$1.11	$1.07
Financial Position:					
Cash and investments	$16,344	$13,675	$11,681	$11,482	$10,938
Total assets	27,178	25,396	24,678	23,497	20,719
Benefits payable	4,668	4,563	4,976	4,475	3,893
Debt	4,920	4,092	4,093	3,795	2,584
Stockholders’ equity	9,842	10,685	10,346	9,646	9,316
Cash flows from operations	$4,051	$1,936	$868	$1,618	$1,716
Key Financial Indicators:					
Benefit ratio	83.0%	84.9%	84.5%	83.0%	83.9%
Operating cost ratio	12.3%	13.3%	13.6%	15.9%	15.5%
Membership by Segment:					
Retail segment:					
Medical membership	9,206,300	8,751,300	8,327,700	7,360,300	5,953,900
Group and Specialty segment:					
Medical membership	4,638,200	4,793,300	4,963,400	5,430,200	5,501,600
Specialty membership	6,986,000	6,961,200	7,221,800	7,668,500	7,823,300
Individual commercial segment:					
Medical membership	128,800	654,800	899,100	1,016,200	505,400
Other Businesses:					
Medical membership	29,800	30,800	32,600	35,000	23,400
Consolidated:					
Total medical membership	14,003,100	14,230,200	14,222,800	13,841,700	11,984,300
Total specialty membership	6,986,000	6,961,200	7,221,800	7,668,500	7,823,300

(a) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505

million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

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

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

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

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

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective.

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

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. On February 16, 2017, under the terms of the Merger Agreement, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned Merger termination fee and related costs, net. Prior period Merger related transaction costs, previously included in operating costs, have been reclassified to conform to the 2017 presentation.

Acquisitions and Divestitures

On December 19, 2017, we announced that we have entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division (Kindred at Home) of Kindred Healthcare, Inc. (Kindred)(NYSE: KND), the nation's largest home health provider and second largest hospice operator, for estimated cash consideration of approximately $800 million, including our share of transaction and related expenses, to facilitate a complete separation from the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital company).

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies. See Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, for a discussion of our closed block of long-term care insurance policies.

These transactions are more fully discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Business Segments

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to

evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation. See Note 17 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data for segment financial information.

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

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts. In addition, the Retail segment also includes our contract with CMS to administer the Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, which we refer to collectively as our state-based contracts. The Group and Specialty segment consists of employer group commercial fully-insured medical and specialty health insurance benefits marketed to individuals and employer groups, including dental, vision, and other supplemental health and voluntary insurance benefits, and financial protection products, as well as administrative services only, or ASO products. In addition, our Group and Specialty segment includes military services business, primarily our TRICARE contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, and clinical care service, such as home health and other services and capabilities to promote wellness and advance population health. The Individual Commercial segment consists of our individual commercial fully-insured medical health insurance benefits. We report under the category of Other Businesses those businesses that do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

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

Seasonality

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

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income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare marketing season.

Our Group and Specialty segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group and Specialty segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses.

Certain of our fully-insured individual commercial medical products in our Individual Commercial segment experience seasonality in the benefit ratio similar to the Group and Specialty segment, including the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers. As previously underwritten members transition, it results in policy lapses and the release of reserves for future policy benefits partially offset by the recognition of previously deferred acquisition costs. The recognition of a premium deficiency reserve for our Individual Commercial medical business compliant with the Health Care Reform Law in the fourth quarter of 2015, and subsequent changes in estimate, also impacted the quarterly benefit ratio pattern for this business in 2016.

Highlights

Consolidated

- Our 2017 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2017, approximately 1,901,300 members, or 66.5%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,816,300 members, or 64.0%, at December 31, 2016.
- Our consolidated pretax results of $4.02 billion for 2017, an increase of $2.47 billion, from $1.55 billion in 2016, primarily reflects the net gain associated with the terminated Merger Agreement, mainly the break-up fee, along with the year-over-year improvement in earnings for our Individual Commercial, Retail and Group and Specialty segments. The year-over-year comparison was also favorably impacted by the reserve strengthening for our non-strategic closed block of long-term care insurance business recorded in 2016. These items were partially offset by lower pretax earnings in the Healthcare Services segment, charges associated with voluntary and involuntary workforce reduction programs recorded during the second half of 2017, as well as the estimated guaranty fund assessment expense to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company).
- Year-over-year comparisons of diluted earnings per common share reflect the same factors impacting our consolidated pretax income comparisons year-over-year as well as the beneficial effect of the lower effective tax rate in light of pricing and benefit design assumptions associated with the 2017 temporary suspension of the health insurance industry fee. In addition the year-over-year comparisons were favorably impacted by lower number of shares, primarily reflecting share repurchases.

- We recorded a net gain associated with the terminated Merger Agreement, consisting primarily of the breakup fee, of approximately $936 million, or $4.31 per diluted common share, during 2017. During 2016, we recorded transaction costs in connection with the Merger of approximately $104 million, or $0.64 per diluted common share. Certain costs associated with the Merger were previously not deductible for tax purposes, but became deductible, and were recorded as such, in the first quarter 2017 as a result of the termination of the Merger Agreement.
- During 2017, we initiated a voluntary early retirement program and an involuntary workforce reduction program. These programs impacted approximately 3,600 associates, or 7.8% of our workforce. As a result, we recorded charges of $148 million, or $0.64 per diluted common share. This charge is included with operating costs in the consolidated statements of income for the year ended December 31, 2017 and included at the corporate level in the segment financial information. Payments under these programs are made upon termination during the early retirement or severance pay period, beginning in the first quarter of 2018. We expect this liability to be primarily paid within the next 12 months and classified it as a current liability, included in our consolidated balance sheet in the trade accounts payable and accrued expenses line.
- On March 1, 2017, a court ordered the liquidation of Penn Treaty (an unaffiliated long-term care insurance company), which triggered assessments from state guaranty associations that resulted in our recording a $54 million, or $0.24 per diluted common share, charge in operating costs.
- The annual health insurance industry fee has been suspended for calendar year 2017 but has resumed in calendar year 2018. Operating cost associated with the health insurer fee attributable to 2016 was $916 million. This fee is not deductible for tax purposes, which significantly increased our effective income tax rate. The one-year suspension in 2017 of the health insurer fee has significantly reduced our operating costs and effective tax rate during 2017. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurer fee, but the fee is scheduled to resume in calendar year 2020.
- Investment income increased $16 million in 2017, primarily due to higher average invested balances and interest rates in 2017, partially offset by lower realized capital gains.
- Operating cash flow provided by operations was $4.1 billion for the year ended December 31, 2017 as compared to operating cash flow provided by operations of $1.9 billion for the year ended December 31, 2016. The increase in operating cash flow primarily was due to the receipt of the merger termination fee, net of related expenses and taxes paid, higher earnings and the timing of working capital items.
- We paid dividends to stockholders of $220 million in 2017 as compared to $177 million in 2016.

Retail Segment

- In 2017, our Retail segment pretax income increased by $288 million, or 17.0%, from 2016 primarily driven by the year-over-year improvement in our Medicare Advantage business.

On February 1, 2018, CMS issued its preliminary 2019 Medicare Advantage and Part D payment rates and proposed policy changes, which we refer to collectively as the Advance Notice. CMS has invited public comment on the Advance Notice before publishing final rates on April 2, 2018 (the Final Notice). In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 1.84 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee for service county re-basing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. CMS' estimate includes 30 basis points of negative impact associated with the proposed Employer Group Waiver Plan Payment Policy for 2019. Excluding that item, CMS' estimate would be a 2.14 percent increase. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS' web site, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate, excluding the impact attributable to the Employer Group Waiver Plan Payment Policy.

Group and Specialty Segment

- Group and Specialty segment pretax income was $412 million in 2017, an increase of $68 million, or 19.8%, from $344 million in 2016 primarily reflecting the impact of higher pretax earnings associated with our fully-insured commercial medical products as well as higher earnings from our military services business resulting from higher performance incentives earned under the TRICARE contract.

On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the contract for the new TRICARE T2017 East Region. The T2017 East Region contract is a consolidation of the former T3 North and South Regions, comprising thirty-two states and approximately six million TRICARE beneficiaries, with delivery of health care services commencing on January 1, 2018. The T2017 East contract is a 5-year contract set to expire on December 31, 2022.

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Healthcare Services Segment

- Healthcare Services segment pretax income was $967 million in 2017, a decrease $129 million, or 11.8%, from 2016 primarily due to the impact of the optimization process associated with our chronic care management programs, as well as lower earnings in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. The reductions in pharmacy solutions intersegment revenues were offset by similar reductions in operating costs associated with the pharmacy solutions business.
- At December 31, 2017, approximately 52,200 primary care providers were in value-based relationships, an increase of 3.6% from 50,400 at December 31, 2016. At December 31, 2017, 66% of our individual Medicare Advantage members were in value-based relationships compared to 64% at December 31, 2016.
- Medicare Advantage and dual demonstration program membership enrolled in a Humana chronic care management program was 794,900 at December 31, 2017, a decrease of 27.7% from 1,099,200 at December 31, 2016. We have undergone an optimization process that ensures the appropriate level of member interaction with clinicians to drive quality outcomes, which has resulted in reduced segment earnings but higher returns on investment.

Individual Commercial Segment

- As announced on February 14, 2017, we exited our Individual Commercial medical business January 1, 2018.
- In 2017, our Individual Commercial segment pretax income was $193 million, an increase of $1.1 billion, from a pretax loss of $869 million in 2016 primarily due to the exit of certain markets in 2017, and per-member premium increases, as well as the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry is $14.3 billion in 2018 and is not deductible for income tax purposes, which significantly increases our effective income tax rate. A one year suspension in 2017 and 2019 of the health insurer fee significantly impacts our trend in key operating metrics including our operating cost and medical expense ratios, as well as our effective tax rate.

In addition, the Health Care Reform Law expands federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which

began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this 2017 Form 10-K.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. For 2017, we offered on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. Effective January 1, 2018, we have exited our remaining Individual Commercial medical business.

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

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

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer’s statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2017, we collected approximately $39 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and clinical care services, to our Retail, Group and Specialty, and Individual Commercial segment customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2017 Form 10-K.

Comparison of Results of Operations for 2017 and 2016

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2017 and 2016:

Consolidated

	2017	2016	Change Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$44,626	$43,223	$1,403	3.2 %
Group and Specialty	6,772	6,696	76	1.1 %
Individual Commercial	947	3,064	(2,117)	(69.1)%
Other Businesses	35	38	(3)	(7.9)%
Total premiums	52,380	53,021	(641)	(1.2)%
Services:				
Retail	10	6	4	66.7 %
Group and Specialty	626	643	(17)	(2.6)%
Healthcare Services	338	310	28	9.0 %
Other Businesses	8	10	(2)	(20.0)%
Total services	982	969	13	1.3 %
Investment income	405	389	16	4.1 %
Total revenues	53,767	54,379	(612)	(1.1)%
Operating expenses:				
Benefits	43,496	45,007	(1,511)	(3.4)%
Operating costs	6,567	7,173	(606)	(8.4)%
Merger termination fee and related costs, net	(936)	104	(1,040)	(1,000.0)%
Depreciation and amortization	378	354	24	6.8 %
Total operating expenses	49,505	52,638	(3,133)	(6.0)%
Income from operations	4,262	1,741	2,521	144.8 %
Interest expense	242	189	53	28.0 %
Income before income taxes	4,020	1,552	2,468	159.0 %
Provision for income taxes	1,572	938	634	67.6 %
Net income	$2,448	$614	$1,834	298.7 %
Diluted earnings per common share	$16.81	$4.07	$12.74	313.0 %
Benefit ratio (a)	83.0 %	84.9 %		(1.9)%
Operating cost ratio (b)	12.3 %	13.3 %		(1.0)%
Effective tax rate	39.1 %	60.5 %		(21.4)%

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

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

Summary

Net income for 2017 was $2.4 billion, or $16.81 per diluted common share compared to $614 million, or $4.07 per diluted common share, in 2016. Net income in 2017 includes a net gain of $4.31 per diluted common share associated with the terminated Merger Agreement consisting primarily of the break-up fee, and the beneficial effect of the lower effective tax rate in light of pricing and benefit design assumptions with the temporary suspension of the health insurance industry fee of $2.15 per diluted common share, excluding the Individual Commercial business impact. The year-over-year comparison was also favorably impacted by a write-off of $2.43 per diluted common share in receivables associated with the commercial risk corridor premium stabilization program, and the reserve strengthening for our non-strategic closed block of long-term care insurance business of $2.11 per common diluted share recorded in 2016. These items were partially offset by the impact of the tax reform law enacted on December 22, 2017, or the Tax Reform Law, which resulted in the reduction of our net income due to the remeasurement of deferred tax assets at lower enacted corporate tax rates of $0.92 per diluted common share, $0.64 per common diluted share in charges associated with both voluntary and involuntary workforce reduction programs in 2017, as well as the estimated guaranty fund assessment expense to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company) of $0.24 per diluted common share. Excluding the impacts of the items above, the increase in net income primarily was due to year-over-year improvements in earnings for our Individual Commercial, Retail, and Group and Specialty segments, partially offset by lower earnings in the Healthcare Services segment.

Premiums Revenue

Consolidated premiums decreased $641 million, or 1.2%, from 2016 to $52.4 billion for 2017 primarily due to lower premiums in the Individual Commercial segment, partially offset by higher premiums in the Retail segment, primarily resulting from growth in our Medicare Advantage business, and higher premiums in the Group and Specialty segment, as discussed in the detailed segment results discussion that follows.

Services Revenue

Consolidated services revenue increased $13 million, or 1.3%, from 2016 for 2017 primarily due to an increase in services revenue in the Healthcare Services segment, partially offset by a decrease in services revenue in the Group and Specialty segment as discussed in the detailed segment results discussion that follows.

Investment Income

Investment income was $405 million for 2017, increasing $16 million, or 4.1%, from 2016, primarily due higher average invested balances and interest rates in 2017, partially offset by lower realized capital gains.

Benefits Expense

Consolidated benefits expense was $43.5 billion for 2017, a decrease of $1.5 billion, or 3.4%, from 2016 reflecting $505 million in incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies recorded in 2016. Excluding the long-term care reserve strengthening in 2016, the decrease primarily was due to a decrease in the Individual Commercial segment benefits expense, partially offset by an increase in the Retail and Group and Specialty segments benefits expense as discussed in the detailed segment results discussion that follows. As more fully described herein under the section entitled “Benefits Expense Recognition”, actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017 and $582 million in 2016.

The consolidated benefit ratio for 2017 was 83.0%, a decrease of 190 basis points from 2016 primarily due to the incremental benefits expense in 2016 for the reserve strengthening in our non-strategic closed block of long-term care insurance policies. Excluding the impact of the above, the decrease in the consolidated benefit ratio primarily was due to the decrease in the Individual Commercial segment benefit ratio, partially offset by the increase in the Retail and Group and Specialty segment benefit ratio as discussed in the segment results of operation discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 90 basis points in 2017 versus approximately 110 basis points in 2016.

Operating Costs

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

Consolidated operating costs decreased $606 million, or 8.4%, from 2016 to $6.6 billion in 2017 primarily due to the temporary suspension of the health insurance industry fee for the calendar year 2017 and lower Individual Commercial membership. This was partially offset by charges associated with both voluntary and involuntary workforce reduction programs, an increase in employee compensation costs resulting from the continued strong performance, increased spending associated with the Medicare Annual Election Period, or AEP, as well as the estimated guaranty fund assessment expense recorded to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company).

The consolidated operating cost ratio for 2017 was 12.3%, decreasing 100 basis points from 2016 primarily due to the temporary suspension of the health insurance industry fee for the calendar year 2017, the write-off of receivables associated with the commercial risk corridor premium stabilization program in 2016, as well as operating cost efficiencies, partially offset by the loss of scale efficiency from market exits in the 2017 period associated with the Individual Commercial product, the estimated charges associated with both voluntary and involuntary workforce reduction programs recorded in 2017, increased employee compensation costs resulting from the continued strong performance, as well as the impact of the estimated guaranty fund assessment expense recorded to support the policyholder obligations of Penn Treaty (an unaffiliated long-term care insurance company). The non-deductible health insurance industry fee impacted the operating cost ratio by 170 basis points in 2016.

Depreciation and Amortization

Depreciation and amortization for 2017 of $378 million was relatively unchanged from 2016.

Interest Expense

Interest expense was $242 million for 2017 compared to $189 million for 2016, an increase of $53 million, or 28.0%, due to the issuance of $1.8 billion in senior notes, a portion of the proceeds which were used to redeem $800 million of senior notes scheduled to mature in 2018. We recognized a loss on extinguishment of debt of approximately $17 million in December 2017 for the redemption of these senior notes, which is included in interest expense.

Income Taxes

Our effective tax rate during 2017 was 39.1% compared to the effective tax rate of 60.5% in 2016 primarily reflecting the suspension of the annual health insurance industry fee in 2017, as well as previously non-deductible transaction costs that, as a result of termination of the Merger Agreement, became deductible for tax purposes and were recorded as such in the first quarter of 2017, partially offset by the Tax Reform Law, which increased our effective tax rate due to the remeasurement of deferred tax assets at lower enacted corporate tax rates. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

The tax reform law enacted on December 22, 2017 significantly reduced our federal corporate tax rate. As a result, we expect our effective tax rate for 2018 to be approximately 32.5% to 33.5%. The decline in the effective tax rate for 2018 primarily is due to the enactment of tax reform, partially offset by the resumption of the annual health insurance industry fee in 2018.

Retail Segment

	2017	2016	Change Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,860,800	2,837,600	23,200	0.8 %
Group Medicare Advantage	441,400	355,400	86,000	24.2 %
Medicare stand-alone PDP	5,308,100	4,951,400	356,700	7.2 %
Total Retail Medicare	8,610,300	8,144,400	465,900	5.7 %
State-based Medicaid	360,100	388,100	(28,000)	(7.2)%
Medicare Supplement	235,900	218,800	17,100	7.8 %
Total Retail medical members	9,206,300	8,751,300	455,000	5.2 %

	2017	2016	Change Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$32,720	$31,863	$857	2.7 %
Group Medicare Advantage	5,155	4,283	872	20.4 %
Medicare stand-alone PDP	3,702	4,009	(307)	(7.7)%
Total Retail Medicare	41,577	40,155	1,422	3.5 %
State-based Medicaid	2,571	2,640	(69)	(2.6)%
Medicare Supplement	478	428	50	11.7 %
Total premiums	44,626	43,223	1,403	3.2 %
Services	10	6	4	66.7 %
Total premiums and services revenue	$44,636	$43,229	$1,407	3.3 %
Income before income taxes	$1,978	$1,690	$288	17.0 %
Benefit ratio	85.6 %	85.1 %		0.5 %
Operating cost ratio	9.6 %	10.8 %		(1.2)%

Pretax Results

- Retail segment pretax income was $2.0 billion in 2017, an increase of $288 million, or 17.0%, compared to 2016 primarily driven by the year-over-year improvement in our Medicare Advantage business.

Enrollment

- Individual Medicare Advantage membership increased 23,200 members, or 0.8%, from December 31, 2016 to December 31, 2017 reflecting net membership additions for Medicare beneficiaries including the effect of planned market and product exits in 2017. We decided certain markets and/or products were not meeting long term strategic and financial objectives. Additionally, membership growth was muted due to competitive actions including the uncertainty associated with the then-pending Merger transaction during last year's AEP. For full year 2018, we anticipate net membership growth in our individual Medicare Advantage offerings of 180,000 to 200,000.
- Group Medicare Advantage membership increased 86,000 members, or 24.2%, from December 31, 2016 to December 31, 2017 reflecting the addition of a large account in January 2017. For full year 2018, we anticipate net membership growth in our group Medicare Advantage offerings of 65,000 to 70,000.

- Medicare stand-alone PDP membership increased 356,700 members, or 7.2%, from December 31, 2016 to December 31, 2017 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2017 plan year. For full year 2018, we anticipate a net membership decline in our Medicare stand-alone PDP offerings of 280,000 to 320,000, primarily attributable to the loss of auto assign members in Florida and South Carolina due to pricing over the CMS low income benchmark and continued membership declines in our Enhanced Plan offering.
- State-based Medicaid membership decreased 28,000 members, or 7.2%, from December 31, 2016 to December 31, 2017, primarily driven by lower membership associated with our Florida contracts resulting from network realignments.

Premiums revenue

- Retail segment premiums increased $1.4 billion, or 3.2%, from 2016 to 2017 primarily due to Medicare Advantage membership growth and increased per-member premiums for certain of the segment's products. Average group and individual Medicare Advantage membership increased 3.4% in 2017. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per-member premiums. Items impacting average per-member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Benefits expense

- The Retail segment benefit ratio of 85.6% for 2017 increased 50 basis points from 2016 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing and benefit design of our products, margin compression associated with the competitive environment in the group Medicare Advantage business and slightly lower favorable prior-period medical claims reserve development. These increases were partially offset by the impact of planned exits from certain Medicare Advantage markets that carried a higher benefit ratio than other markets as well as lower than expected medical costs as compared to the assumptions used in the pricing of our individual Medicare Advantage business.
- The Retail segment’s benefits expense for 2017 included the beneficial effect of $386 million in favorable prior-year medical claims reserve development versus $429 million in 2016. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 90 basis points in 2017 versus approximately 100 basis points in 2016.

Operating costs

- The Retail segment operating cost ratio of 9.6% for 2017 decreased 120 basis points from 2016 primarily due to the temporary suspension of the health insurance industry fee for calendar year 2017, partially offset by increased spending associated with AEP, investments in our integrated care delivery model, and the increase in employee compensation costs resulting from the continued strong performance. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016.

Group and Specialty Segment

	2017	2016	Change Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,097,700	1,136,000	(38,300)	(3.4)%
ASO	458,700	573,200	(114,500)	(20.0)%
Military services	3,081,800	3,084,100	(2,300)	(0.1)%
Total group medical members	4,638,200	4,793,300	(155,100)	(3.2)%
Specialty membership (a)	6,986,000	6,961,200	24,800	0.4 %

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

	2017	2016	Change Dollar	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$5,462	$5,405	$57	1.1 %
Specialty	1,310	1,279	31	2.4 %
Military services	—	12	(12)	(100.0)%
Total premiums	6,772	6,696	76	1.1 %
Services	626	643	(17)	(2.6)%
Total premiums and services revenue	$7,398	$7,339	$59	0.8 %
Income before income taxes	$412	$344	$68	19.8 %
Benefit ratio	79.2 %	78.2 %		1.0 %
Operating cost ratio	21.4 %	23.5 %		(2.1)%

Pretax Results

- Group and Specialty segment pretax income was $412 million in 2017, an increase of $68 million, or 19.8%, from $344 million in 2016 primarily reflecting the impact of higher pretax earnings associated with our fully-insured commercial business as well as higher earnings from our military services business resulting from higher performance incentives earned under the TRICARE contract.

Enrollment

- Fully-insured commercial group medical membership decreased 38,300 members, or 3.4% from December 31, 2016 reflecting lower membership in small group accounts due in part to more small group accounts selecting ASO products in 2017.
- Group ASO commercial medical membership decreased 114,500 members, or 20.0%, from December 31, 2016 to December 31, 2017 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment, partially offset by more small group accounts selecting ASO products in 2017.
- Specialty membership increased 24,800 members, or 0.4%, from December 31, 2016 to December 31, 2017 primarily due to strong growth in vision products marketed to employer groups.

Premiums revenue

- Group and Specialty segment premiums increased $76 million, or 1.1%, from 2016 to 2017 primarily due to an increase in group fully-insured commercial medical per-member premiums, partially offset by a decline in average group fully-insured commercial medical membership.

Services revenue

- Group and Specialty segment services revenue decreased $17 million, or 2.6%, from 2016 to 2017 primarily due to a decline in revenue in our group ASO commercial medical business mainly due to membership declines partially offset by higher revenue from our military services business resulting from higher performance incentives earned under the TRICARE contract.

Benefits expense

- The Group and Specialty segment benefit ratio increased 100 basis points from 78.2% in 2016 to 79.2% in 2017 primarily due to the impact of the temporary suspension of the health insurance industry fee for calendar year 2017 which was contemplated in the pricing of our products. The increase was further impacted by an increased proportion of small group members transitioning to community rated plans that carry a higher benefit ratio. These increases were partially offset by lower utilization for the fully-insured commercial medical business in 2017, primarily associated with the large group business.
- The Group and Specialty segment's benefits expense included the beneficial effect of $40 million in favorable prior-year medical claims reserve development in 2017 versus $46 million in 2016. This favorable prior-year medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 60 basis points in 2017 versus approximately 70 basis points in 2016.

Operating costs

- The Group and Specialty segment operating cost ratio of 21.4% for 2017 decreased 210 basis points from 23.5% for 2016 primarily due to the temporary suspension of the health insurance industry fee for calendar year 2017 as well as operating cost efficiencies, partially offset by an increase in employee compensation costs resulting from the continued strong performance. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016.

Healthcare Services Segment

	2017	2016	Change Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$181	$201	$(20)	(10.0)%
Pharmacy solutions	80	31	49	158.1 %
Provider services	77	78	(1)	(1.3)%
Total services revenues	338	310	28	9.0 %
Intersegment revenues:				
Pharmacy solutions	20,881	21,952	(1,071)	(4.9)%
Provider services	1,593	1,677	(84)	(5.0)%
Clinical care services	1,111	1,343	(232)	(17.3)%
Total intersegment revenues	23,585	24,972	(1,387)	(5.6)%
Total services and intersegment revenues	$23,923	$25,282	$(1,359)	(5.4)%
Income before income taxes	$967	$1,096	$(129)	(11.8)%
Operating cost ratio	95.5 %	95.2 %		0.3 %

Pretax results

- Healthcare Services segment pretax income was $967 million in 2017, a decrease of $129 million, or 11.8%, from 2016 primarily was due to the impact of the optimization process associated with our chronic care management programs, as well as lower earnings in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. The reductions in pharmacy solutions intersegment revenues were offset by similar reductions in operating costs associated with the pharmacy solutions business.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group and Specialty segment membership increased to approximately 433 million in 2017, up 2% versus scripts of approximately 426 million in 2016. The increase primarily reflects growth associated with higher Medicare membership for 2017 than in 2016, partially offset by the decline in Individual Commercial membership.

Services revenue

- Services revenue increased $28 million, or 9.0%, from 2016 to $338 million for 2017 primarily due to service revenue growth from our pharmacy solutions business.

Intersegment revenues

- Intersegment revenues decreased $1.4 billion, or 5.6%, from 2016 to $23.6 billion for 2017 primarily due to our pharmacy solutions business as well as the result of the optimization process associated with our chronic care management programs discussed previously, as well as lower revenue in our provider services business reflecting lower Medicare rates year-over-year in geographies where our provider assets are primarily located. Our pharmacy solutions business revenues were impacted by improvements in net pharmacy costs driven by our pharmacy benefit manager and an increase in the generic dispensing rate. These items were partially offset by higher year-over-year script volume from growth in our Medicare Advantage and standalone PDP membership, partially offset by the impact of lower Individual Commercial membership. Our generic dispensing rate improved to 91.3% during 2017 from 90.5% during 2016. The higher generic dispensing rate

reduced revenues (and operating costs) for our pharmacy solutions business as generic drugs are generally priced lower than branded drugs.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.5% for 2017 was relatively unchanged from 95.2% for 2016.

Individual Commercial Segment

- As announced on February 14, 2017, we exited our Individual Commercial medical business January 1, 2018.
- In 2017, our Individual Commercial segment pretax income was $193 million, an increase of $1.1 billion, from a pretax loss of $869 million in 2016 primarily due to the exit of certain markets in 2017, and per-member premium increases, as well as the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program.
- Individual commercial medical membership decreased 526,000 members, or 80.3%, from December 31, 2016 to December 31, 2017 reflecting the decline in the number of counties we offered on-exchange coverage and the discontinuance of offering off-exchange products.
- The Individual Commercial segment benefit ratio of 57.4% for 2017 decreased from 107.7% in 2016 primarily due to the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program, as well as the planned exits in 2017 in certain markets that carried a higher benefit ratio and per-member premium increases.
- The Individual Commercial segment operating cost ratio of 21.2% for 2017 increased 160 basis points from 2016 primarily due to the loss of scale efficiency from market exits in 2017, partially offset by the write-off of receivables associated with the commercial risk corridor premium stabilization program and the temporary suspension of the health insurance industry fee for calendar year 2017.

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2017 Form 10-K.

Comparison of Results of Operations for 2016 and 2015

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

Consolidated

	2016	2015	Change Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$43,223	$41,605	$1,618	3.9 %
Group and Specialty	6,696	6,830	(134)	(2.0)%
Individual Commercial	3,064	3,939	(875)	(22.2)%
Other Businesses	38	35	3	8.6 %
Total premiums	53,021	52,409	612	1.2 %
Services:				
Retail	6	8	(2)	(25.0)%
Group and Specialty	643	658	(15)	(2.3)%
Healthcare Services	310	726	(416)	(57.3)%
Other Businesses	10	14	(4)	(28.6)%
Total services	969	1,406	(437)	(31.1)%
Investment income	389	474	(85)	(17.9)%
Total revenues	54,379	54,289	90	0.2 %
Operating expenses:				
Benefits	45,007	44,269	738	1.7 %
Operating costs	7,173	7,295	(122)	(1.7)%
Merger termination fee and related costs, net	104	23	81	352.2 %
Depreciation and amortization	354	355	(1)	(0.3)%
Total operating expenses	52,638	51,942	696	1.3 %
Income from operations	1,741	2,347	(606)	(25.8)%
Gain on sale of business	—	270	(270)	(100.0)%
Interest expense	189	186	3	1.6 %
Income before income taxes	1,552	2,431	(879)	(36.2)%
Provision for income taxes	938	1,155	(217)	(18.8)%
Net income	$614	$1,276	$(662)	(51.9)%
Diluted earnings per common share	$4.07	$8.44	$(4.37)	(51.8)%
Benefit ratio (a)	84.9 %	84.5 %		0.4 %
Operating cost ratio (b)	13.3 %	13.6 %		(0.3)%
Effective tax rate	60.5 %	47.5 %		13.0 %

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

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

Summary

Net income was $614 million, or $4.07 per diluted common share, in 2016 compared to $1.3 billion, or $8.44 per diluted common share, in 2015. Net income includes a write-off of $2.43 per diluted common share in receivables associated with the commercial risk corridor premium stabilization program and reserve strengthening for our non-strategic closed block of long-term care insurance business of $2.11 per diluted common share, as discussed below. These items were partially offset by the impact of the premium deficiency reserve of $0.74 per diluted common share recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. In addition, the completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain of $1.57 per diluted common share in 2015. Excluding these items, the increase primarily was due to year-over-year improvement in results for our individual Medicare Advantage business and our Healthcare Services segment as well as increased profitability in our state-based Medicaid business, partially offset by an increase in the effective tax rate as discussed below. In addition, 2016 includes expenses of $0.64 per diluted common share and 2015 includes expenses of $0.14 per diluted common share for transaction and integration planning costs associated with the Merger, certain of which were not deductible for tax purposes until 2017.

Premiums Revenue

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

Services Revenue

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

Investment Income

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

Benefits Expense

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

The consolidated benefit ratio for 2016 was 84.9%, an increase of 40 basis points from 2015 primarily due to the incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies, the impact on the benefit ratio of lower consolidated premiums associated with the write-off of receivables for the commercial risk corridor premium stabilization program, and the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the impact of the write-off of the commercial risk corridor receivables and the premium deficiency reserve, these items were partially offset by year-over-year improvement in both the Retail and Group and Specialty segment benefit ratios as discussed in the segment results of operations discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 110 basis points in 2016 versus approximately 50 basis points in 2015.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent. Consolidated operating costs decreased $122 million, or 1.7%, from 2015 to $7.2 billion in 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

The consolidated operating cost ratio for 2016 was 13.3%, decreasing 30 basis points from 2015 primarily due to the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio than our Group and Specialty and Retail segments. This was partially offset by the unfavorable year-over-year comparison associated with the temporary suspension of certain discretionary administrative costs in the latter half of 2015, along with the impact of the commercial risk corridor receivables write-off in the fourth quarter of 2016.

Depreciation and Amortization

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

Interest Expense

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

Income Taxes

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

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

Retail Segment

	2016	2015	Change Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,837,600	2,753,400	84,200	3.1 %
Group Medicare Advantage	355,400	484,100	(128,700)	(26.6)%
Medicare stand-alone PDP	4,951,400	4,557,900	393,500	8.6 %
Total Retail Medicare	8,144,400	7,795,400	349,000	4.5 %
State-based Medicaid	388,100	373,700	14,400	3.9 %
Medicare Supplement	218,800	158,600	60,200	38.0 %
Total Retail medical members	8,751,300	8,327,700	423,600	5.1 %

	2016	2015	Change Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$31,863	$29,526	$2,337	7.9 %
Group Medicare Advantage	4,283	5,588	(1,305)	(23.4)%
Medicare stand-alone PDP	4,009	3,846	163	4.2 %
Total Retail Medicare	40,155	38,960	1,195	3.1 %
State-based Medicaid	2,640	2,341	299	12.8 %
Medicare Supplement	428	304	124	40.8 %
Total premiums	43,223	41,605	1,618	3.9 %
Services	6	8	(2)	(25.0)%
Total premiums and services revenue	$43,229	$41,613	$1,616	3.9 %
Income before income taxes	$1,690	$1,259	$431	34.2 %
Benefit ratio	85.1 %	86.7 %		(1.6)%
Operating cost ratio	10.8 %	10.3 %		0.5 %

Pretax Results

- Retail segment pretax income was $1,690 million in 2016, an increase of $431 million, or 34.2%, compared to 2015 primarily driven by the year-over-year improvement in our individual Medicare Advantage and state-based Medicaid businesses.

Enrollment

- Individual Medicare Advantage membership increased 84,200 members, or 3.1%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, particularly for our HMO offerings, for the 2016 plan year.
- Group Medicare Advantage membership decreased 128,700 members, or 26.6%, from December 31, 2015 to December 31, 2016 reflecting the loss of a large account that moved to a private exchange offering on January 1, 2016.

- Medicare stand-alone PDP membership increased 393,500 members, or 8.6%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2016 plan year.
- State-based Medicaid membership increased 14,400 members, or 3.9%, from December 31, 2015 to December 31, 2016 primarily driven by the addition of members under our Florida Medicaid contract.

Premiums revenue

- Retail segment premiums increased $1,618 million, or 3.9%, from 2015 to 2016 primarily due to higher average membership for our individual Medicare Advantage and state-based Medicaid businesses and per member premium increases for certain lines of business. Average individual Medicare Advantage membership increased 3.9% in 2016.

Benefits expense

- The Retail segment benefit ratio of 85.1% for 2016 decreased 160 basis points from 2015 primarily due to lower year-over-year Medicare Advantage utilization, and favorable comparisons of prior-year medical claims reserve development.
- The Retail segment's benefits expense for 2016 included the beneficial effect of $429 million in favorable prior-year medical claims reserve development versus $248 million in 2015. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 100 basis points in 2016 versus approximately 60 basis points in 2015. The year-over-year increase in prior-period medical claims reserve development primarily was due to favorable year-over-year comparisons for our Medicare Advantage business.

Operating costs

- The Retail segment operating cost ratio of 10.8% for 2016 increased 50 basis points from 2015 primarily due to the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs, and the loss of a large group Medicare Advantage account which carried a lower operating cost ratio than that for our individual Medicare Advantage business. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016 as compared to 160 basis points in 2015.

Group and Specialty Segment

			Change	
	2016	2015	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,136,000	1,178,300	(42,300)	(3.6)%
ASO	573,200	710,700	(137,500)	(19.3)%
Military services	3,084,100	3,074,400	9,700	0.3 %
Total group medical members	4,793,300	4,963,400	(170,100)	(3.4)%
Specialty membership (a)	6,961,200	7,221,800	(260,600)	(3.6)%

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

	2016	2015	Change Dollars	Change Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$5,405	$5,493	$(88)	(1.6)%
Specialty	1,279	1,316	(37)	(2.8)%
Military services	12	21	(9)	(42.9)%
Total premiums	6,696	6,830	(134)	(2.0)%
Services	643	658	(15)	(2.3)%
Total premiums and services revenue	$7,339	$7,488	$(149)	(2.0)%
Income before income taxes	$344	$321	$23	7.2 %
Benefit ratio	78.2 %	78.8 %		(0.6)%
Operating cost ratio	23.5 %	23.4 %		0.1 %

Pretax Results

- Group and Specialty segment pretax income was $344 million in 2016, an increase of $23 million, or 7.2%, from $321 million in 2015 driven by the improvement in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 42,300 members, or 3.6% from December 31, 2015 reflecting lower membership in both large and small group accounts.
- Group ASO commercial medical membership decreased 137,500 members, or 19.3%, from December 31, 2015 to December 31, 2016 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.
- Specialty membership decreased 260,600 members, or 3.6%, from December 31, 2015 to December 31, 2016 primarily due to the loss of several large stand-alone dental and vision accounts as well as the loss of certain fully-insured group medical accounts that also had specialty coverage. The decrease includes the loss of certain individual commercial medical members that also had specialty coverage.

Premiums revenue

- Group and Specialty segment premiums decreased $134 million, or 2.0%, from 2015 to 2016 primarily due to a decline in fully-insured commercial medical membership as described above, partially offset by an increase in fully-insured commercial medical per member premiums.

Services revenue

- Group and Specialty segment services revenue decreased $15 million, or 2.3%, from 2015 to 2016 primarily due to a decline in group ASO commercial medical membership.

Benefits expense

- The Group and Specialty segment benefit ratio decreased 60 basis points from 78.8% in 2015 to 78.2% in 2016 primarily reflecting the beneficial effect of higher prior-year medical claims reserve development in 2016 and lower utilization.
- The Group and Specialty segment’s benefits expense included the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2016 versus $7 million in 2015. This favorable prior-year

medical claims reserve development decreased the Group and Specialty segment benefit ratio by approximately 70 basis points in 2016 versus approximately 10 basis points in 2015.

Operating costs

- The Group and Specialty segment operating cost ratio of 23.5% for 2016 increased 10 basis points from 23.4% for 2015, primarily due to the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016 as compared to 140 basis points in 2015.

Healthcare Services Segment

	2016	2015	Change Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Clinical care services	$201	$181	$20	11.0 %
Provider services	78	515	(437)	(84.9)%
Pharmacy solutions	31	30	1	3.3 %
Total services revenues	310	726	(416)	(57.3)%
Intersegment revenues:				
Pharmacy solutions	21,952	20,551	1,401	6.8 %
Provider services	1,677	1,291	386	29.9 %
Clinical care services	1,343	1,208	135	11.2 %
Total intersegment revenues	24,972	23,050	1,922	8.3 %
Total services and intersegment revenues	$25,282	$23,776	$1,506	6.3 %
Income before income taxes	$1,096	$1,022	$74	7.2 %
Operating cost ratio	95.2 %	95.0 %		0.2 %

Pretax results

- Healthcare Services segment pretax income of $1,096 million for 2016 increased $74 million, or 7.2%, from 2015 primarily due to incremental earnings associated with revenue growth from our pharmacy solutions business as it increased mail-order penetration and served our growing individual Medicare membership. The increase was partially offset by lower earnings in our provider services business reflecting significantly lower Medicare rates year-over-year associated with CMS' risk coding recalibration for 2016 in geographies where our provider assets are primarily located.

Script Volume

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

Services revenue

- Services revenue decreased $416 million, or 57.3%, from 2015 to $310 million for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $1.9 billion, or 8.3%, from 2015 to $25.0 billion for 2016 primarily due to increased mail order penetration and growth in our individual Medicare Advantage and Medicare stand-alone PDP membership which resulted in increased engagement of members in clinical programs and higher utilization of services across the segment.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.2% for 2016 increased slightly from 2015 primarily due to a higher operating cost ratio for our provider services business reflecting significantly lower Medicare rates year-over-year as discussed above, partially offset by operating cost efficiencies associated with our pharmacy operations.

Individual Commercial Segment

- In 2016, our Individual Commercial segment pretax loss decreased by $436 million, or 100.7%, from 2015 primarily driven by the write-off of commercial risk corridor receivables, partially offset by the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 associated with certain individual commercial medical policies from the 2016 coverage year.
- Individual commercial medical membership decreased 244,300 members, or 27.2%, from December 31, 2015 to December 31, 2016 primarily reflecting the loss of on-exchange members due to product competitiveness, the loss of membership associated with the discontinuance of certain Health Care Reform Law compliant plans in 2016, the loss of membership associated with non-payment of premiums or termination by CMS due to lack of eligibility documentation, and the loss of members subscribing to plans that are not compliant with the Health Care Reform Law.
- The Individual Commercial segment benefit ratio of 107.7% for 2016 increased from 91.1% in 2015 primarily due to the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program, partially offset by the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. As previously disclosed, in the fourth quarter of 2015 we recorded a premium deficiency reserve associated with our 2016 individual commercial offerings compliant with the Health Care Reform Law. During 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense primarily as a result of unfavorable current and projected claims experience.
- The Individual Commercial segment operating cost ratio of 19.6% for 2016 increased 40 basis points from 2015 primarily due to the impact on premiums of the write-off of receivables associated with the commercial risk corridor premium stabilization program. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 200 basis points in 2016 as compared to 170 basis points in 2015.

Other Businesses

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

Liquidity

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

The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law have impacted the timing of our operating cash flows, as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. Net collections under the 3Rs associated with prior coverage years were $440 million in 2017 as compared to $383 million in 2016. As more fully described in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, we wrote off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2017, we collected approximately $39 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016.The remaining net receivable balance associated with the 3Rs was approximately $31 million at December 31, 2017, including the $44 million reinsurance receivable related to the 2016 coverage year, as compared to $456 million at December 31, 2016. The remaining net receivable balance is primarily related to our Individual Commercial medical business which we have exited January 1, 2018.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2017 Form 10-K.

Cash and cash equivalents increased to $4.0 billion at December 31, 2017 from $3.9 billion at December 31, 2016. The change in cash and cash equivalents for the years ended December 31, 2017, 2016 and 2015 is summarized as follows:

	2017	2016	2015
	(in millions)		
Net cash provided by operating activities	$4,051	$1,936	$868
Net cash (used in) provided by investing activities	(2,941)	(1,362)	320
Net cash (used in) provided by financing activities	(945)	732	(552)
Increase in cash and cash equivalents	$165	$1,306	$636

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The increase in operating cash flows in 2017 primarily was due to the receipt of the merger termination fee, net of related expenses and taxes paid, higher earnings and the timing of working capital items. The increase in operating cash flows in 2016 primarily was due to the timing of working capital items and higher earnings exclusive of the commercial risk corridor receivables write-off and the long-term care reserve strengthening in 2016, as well as the gain on sale of Concentra and the recognition of the premium deficiency reserve in 2015 discussed previously.

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

The detail of benefits payable was as follows at December 31, 2017, 2016 and 2015:

				Change		
	2017	2016	2015	2017	2016	2015
	(in millions)					
IBNR (1)	$3,154	$3,422	$3,730	$(268)	$(308)	$476
Reported claims in process (2)	614	654	600	(40)	54	125
Premium deficiency reserve (3)	—	—	176	—	(176)	176
Other benefits payable (4)	900	487	470	413	17	(276)
Total benefits payable	$4,668	$4,563	$4,976	$105	$(413)	$501

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).

(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.

(3) Premium deficiency reserve recognized for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.

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

The increase in benefits payable in 2017 largely was due to an increase in amounts owed under capitated, risk sharing, and quality incentive arrangements, partially offset by a decrease in IBNR. Benefits payable decreased in 2016 primarily due to a decrease in IBNR, as well as the application of 2016 results to the premium deficiency reserve liability recognized in 2015 associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year. There was no premium deficiency reserve liability at December 31, 2016 or 2017. The increase in benefits payable in 2015 largely was due to increases in IBNR and in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuates due to month-end cutoff. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements in 2015, including the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. In addition, benefits payable in 2015 reflects the recognition of the premium deficiency reserve discussed previously.

IBNR decreased during 2017 and 2016 primarily due to declines in individual and fully-insured group commercial membership. The decrease in IBNR during 2016 was also impacted by declines in group Medicare Advantage. IBNR increased during 2015 primarily as a result of individual Medicare Advantage membership growth. As discussed previously, our cash flows are impacted by changes in enrollment. The decline in membership experienced in 2017 and 2016 negatively impacted operating cash flows for those years.

The detail of total net receivables was as follows at December 31, 2017, 2016 and 2015:

				Change		
	2017	2016	2015	2017	2016	2015
	(in millions)					
Medicare	$511	$787	$765	$(276)	$22	$101
Commercial and other	273	579	420	(306)	159	39
Military services	166	32	77	134	(45)	(29)
Allowance for doubtful accounts	(96)	(118)	(101)	22	(17)	(3)
Total net receivables	$854	$1,280	$1,161	(426)	119	108
Reconciliation to cash flow statement:						
Provision for doubtful accounts				20	39	61
Change in receivables acquired, held-for-sale, or disposed from sale of business				—	—	11
Change in receivables per cash flow statement resulting in cash from operations				$(406)	$158	$180

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

The decrease in commercial and other receivables in 2017 as compared to 2016 primarily was due to a decrease in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. The increases in commercial and other receivables in 2016 and 2015 primarily reflect increases in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law.

Military services receivables at December 31, 2017, 2016, and 2015 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our TRICARE South Region contract. The 2017 balance also includes transition-in receivables under our T2017 East Region contract with collection scheduled in 2018.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impacted our operating cash flows as we built receivables for each coverage year that were expected to be collected in subsequent coverage years. Net collections under the 3Rs associated with prior coverage years were $440 million as compared to net collections of $383 million in 2016. The net receivable balance associated with the 3Rs was approximately $31 million at December 31, 2017, including certain amounts recorded in receivables as noted above. The annual health insurance industry fee was suspended for the calendar year 2017, but has resumed in calendar year 2018. The annual health insurance industry fee was also suspended for the calendar year 2019 and is scheduled to resume in calendar year 2020. We paid the federal government annual health insurance industry fees of $916 million in 2016 and $867 million in 2015. We have exited our individual commercial medical business effective January 1, 2018.

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

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $526 million in 2017, $527 million in 2016, and $523 million in 2015.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $2.4 billion in 2017 and $828 million in 2016. Proceeds from sales and maturities of investment securities exceeded purchases by $103 million in 2015. These net proceeds were used to fund normal working capital needs due to an increase in receivables associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below.

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

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

Cash consideration paid for acquisitions, net of cash acquired, was $31 million in 2017, $7 million in 2016, and $38 million in 2015. Acquisitions in each year included Healthcare Services segment related acquisitions.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were $1.9 billion higher than claims payments during 2017 and were $1.1 billion higher than claims payments during 2016. Claim payments were $361 million higher than receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk during 2015. In 2015, we experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher subsidy receivable balances under the terms of our contracts with CMS. Our net payable for CMS subsidies and brand name prescription drug discounts was $1.0 billion at December 31, 2017 compared to a net receivable of $0.9 billion at December 31, 2016. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our administrative services only TRICARE South Region contract, reimbursements from the federal government exceeded health care cost payments for which we do not assume risk by $11 million in 2017. Health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $25 million in 2016 and $4 million in 2015.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $44 million in 2017 and by $28 million in 2016. Claim payments were less than reimbursements by $69 million in 2015. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 12.99 million shares for $3.05 billion in 2017 and 1.85 million shares for $329 million in 2015 under share repurchase plans authorized by the Board of Directors. We did not repurchase shares in 2016 due to restrictions under the Merger Agreement. We also acquired common shares in connection with employee stock plans for an aggregate cost of $115 million in 2017, $104 million in 2016, and $56 million in 2015.

As discussed further below, we paid dividends to stockholders of $220 million in 2017, $177 million in 2016, and $172 million in 2015.

We entered into a commercial paper program in October 2014. Net repayments of commercial paper were $153 million in 2017 and the maximum principal amount outstanding at any one time during 2017 was $500 million. Net repayments of commercial paper were $2 million in 2016 and the maximum principal amount outstanding at any one time during 2016 was $475 million. Net proceeds from the issuance of commercial paper were $298 million in 2015 and the maximum principal amount outstanding at any one time during 2015 was $414 million.

In March 2017, we issued $600 million of 3.95% senior notes due March 15, 2027 and $400 million of 4.80% senior notes due March 15, 2047. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of March 31, 2017, were $991 million. The net proceeds from these issuances are being used for general corporate purposes.

In December 2017, we issued $400 million of 2.50% senior notes due December 15, 2020 and $400 million of 2.90% senior notes due December 15, 2022. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses paid as of December 31, 2017, were $794 million. We used the net proceeds, together with available cash, to fund the redemption of our $300 million aggregate principal amount of 6.30% senior notes maturing in August 2018 and our $500 million aggregate principal amount of 7.20% senior notes maturing in June 2018 at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $829 million.

The remainder of the cash used in or provided by financing activities in 2017, 2016, and 2015 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

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

Stock Repurchases

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

Debt

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 12 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Acquisitions & Divestitures

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary KMG to CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG’s subsidiary, KIC, includes our closed block of non-strategic commercial long-term care insurance policies. We will fund the transaction with approximately $203 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $150 million of statutory capital with the sale. The KMG transaction is anticipated to close by the third quarter of 2018 subject to customary closing conditions, including South Carolina Department of Insurance approval. There can be no assurance we will obtain regulatory approvals needed to sell the business or do so under terms acceptable to us.

On December 19, 2017, we announced that we have entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division (Kindred at Home) of Kindred Healthcare, Inc. (Kindred)(NYSE: KND), the nation's largest home health provider and second largest hospice operator, for estimated cash consideration of approximately $800 million, including our share of transaction and related expenses, to facilitate a complete separation from the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital company). The Kindred transaction, which is anticipated to close in the summer of 2018, is subject to customary state and federal regulatory approvals, including approval by the stockholders of Kindred and the expiration of the waiting period under the Hart-Scott-Rodino Antitrust Improvement Act of 1976, as amended, as well as other customary closing conditions. We expect to fund the transaction through the use of parent company cash and will account for the minority investment under the equity method. The pending transaction did not have a material impact to earnings in 2017.
For a detailed discussion of the above please refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

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

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2017 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company decreased to $688 million at December 31, 2017 from $2.0 billion at December 31, 2016. This decrease primarily reflects common stock repurchases, insurance subsidiaries' capital contributions and capital expenditures, partially offset by insurance subsidiaries dividends, non-insurance subsidiaries' profits and net proceeds from debt issuance. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated subsidiaries paid dividends to the parent of $1.4 billion in 2017, $763 million in 2016, and $493 million in 2015. Subsidiary dividends in 2015 reflect the impact of losses for our individual commercial medical business compliant with the Health Care Reform Law and the November 5, 2015 revised statutory accounting guidance requiring the exclusion of risk corridor receivables from related statutory surplus. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2018 is approximately $1.1 billion, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

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

Regulatory Requirements

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

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2017 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
	(in millions)				
Debt	$4,950	$ 150	$ 1,200	$ 600	$ 3,000
Interest (1)	3,021	200	379	347	2,095
Operating leases (2)	519	152	218	97	52
Purchase obligations (3)	429	226	188	15	—
Future policy benefits payable and other long-term liabilities (4)	3,396	91	482	208	2,615
Total	$12,315	$ 819	$ 2,467	$ 1,267	$ 7,762

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

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2046. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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

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

Off-Balance Sheet Arrangements

As of December 31, 2017, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

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

Government Contracts

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

Other

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. On February 16, 2017, under the terms of the Merger Agreement, we received a breakup fee of $1 billion.

Critical Accounting Policies and Estimates

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

Benefits Expense Recognition

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

	December 31, 2017	Percentage of Total	December 31, 2016	Percentage of Total
	(dollars in millions)			
IBNR	$3,154	67.6 %	$ 3,422	75.0 %
Reported claims in process	614	13.1 %	654	14.3 %
Other benefits payable	900	19.3 %	487	10.7 %
Total benefits payable	$4,668	100.0 %	$ 4,563	100.0 %

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

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderately adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2017 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
(dollars in millions)			
0.60%	$(182)	(2.75)%	$(287)
0.50%	$(152)	(2.50)%	$(261)
0.40%	$(121)	(2.25)%	$(235)
0.30%	$(91)	(2.00)%	$(209)
0.20%	$(61)	(1.75)%	$(183)
0.10%	$(30)	(1.50)%	$(157)
—%	$—	(1.25)%	$(131)

(a) Reflects estimated potential changes in benefits payable at December 31, 2017 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2017 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

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

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail, Group and Specialty, and Individual Commercial segment tables including information about incurred and paid claims development as of December 31, 2017, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2017	2016	2015
	(in millions)		
Balances at January 1	$4,563	$4,976	$4,475
Less: Premium deficiency reserve	—	(176)	—
Less: Reinsurance recoverables	(76)	(85)	(78)
Balances at January 1, net	4,487	4,715	4,397
Incurred related to:			
Current year	44,001	45,318	44,397
Prior years	(483)	(582)	(236)
Total incurred	43,518	44,736	44,161
Paid related to:			
Current year	(39,496)	(40,852)	(39,802)
Prior years	(3,911)	(4,112)	(4,041)
Total paid	(43,407)	(44,964)	(43,843)
Premium deficiency reserve	—	—	176
Reinsurance recoverable	70	76	85
Balances at December 31	$4,668	$4,563	$4,976

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

	Favorable Development by Changes in Key Assumptions					
	2017		2016		2015	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$(279)	(2.6)%	$(316)	(2.9)%	$(145)	(1.5)%
Completion factors	(204)	0.7 %	(266)	0.9 %	(91)	0.4 %
Total	$(483)		$(582)		$(236)	

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017, $582 million in 2016, and $236 million in 2015. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2017, 2016, and 2015.

	Favorable Medical Claims Reserve Development			Change	
	2017	2016	2015	2017	2016
	(in millions)				
Retail Segment	$(386)	$(429)	$(248)	$43	$(181)
Group and Specialty Segment	(40)	(46)	(7)	6	(39)
Individual Commercial Segment	(56)	(106)	20	50	(126)
Other Businesses	(1)	(1)	(1)	—	—
Total	$(483)	$(582)	$(236)	$99	$(346)

The favorable medical claims reserve development for 2017, 2016, and 2015 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2017 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Premium deficiency reserve for short-duration policies	$—	$(176)	$176
Military services	—	8	12
Future policy benefits	(22)	439	(80)
Total	$(22)	$271	$108

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

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

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

Future policy benefits payable of $2.9 billion and $2.8 billion at December 31, 2017 and 2016, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $2.3 billion at December 31, 2017 and $2.2 billion at December 31, 2016 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 29,800 policies remain in force as of December 31, 2017. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was a $168 million additional liability at December 31, 2017 and $77 million additional liability at December 31, 2016. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

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

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

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

In addition, future policy benefits payable includes amounts of $199 million at December 31, 2017, $201 million at December 31, 2016, and $205 million at December 31, 2015 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

Revenue Recognition

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

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

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer’s enrollment and individuals that ultimately may fail to pay, and for estimated rebates under the minimum benefit ratios required under the Health Care Reform Law. Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on

available data and historical trends. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in the current period's revenue.

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

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnoses data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. In April 2017, CMS revised the pace of the phase-in. For 2018, 15% of the risk score will be calculated from claims data submitted through EDS. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Investment Securities

Investment securities totaled $12.3 billion, or 45% of total assets at December 31, 2017, and $9.8 billion, or 39% of total assets at December 31, 2016. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2017 and 2016. The fair value of debt securities were as follows at December 31, 2017 and 2016:

	December 31, 2017	Percentage of Total	December 31, 2016	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$531	4.3 %	$ 786	8.0 %
Mortgage-backed securities	1,610	13.1 %	1,637	16.7 %
Tax-exempt municipal securities	3,889	31.6 %	3,305	33.7 %
Mortgage-backed securities:				
Residential	26	0.2 %	9	0.1 %
Commercial	456	3.7 %	304	3.1 %
Asset-backed securities	408	3.3 %	160	1.7 %
Corporate debt securities	5,382	43.8 %	3,597	36.7 %
Total debt securities	$12,302	100.0 %	$ 9,798	100.0 %

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2017. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $222 million at December 31, 2017 and $276 million at December 31, 2016. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.8 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.9 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 9%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $94 million and $132 million at December 31, 2017 and 2016, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was less than $1 million at December 31, 2017 and December 31, 2016. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial services industry was 30% at December 31, 2017 and 23% at December 31, 2016.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2017:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2017						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$273	$ (1)	$130	$ (1)	$403	$ (2)
Mortgage-backed securities	581	(2)	672	(17)	1,253	(19)
Tax-exempt municipal securities	1,590	(16)	661	(12)	2,251	(28)
Mortgage-backed securities:						
Residential	20	—	3	—	23	—
Commercial	131	(1)	28	(1)	159	(2)
Asset-backed securities	107	—	10	—	117	—
Corporate debt securities	1,297	(10)	804	(27)	2,101	(37)
Total debt securities	$3,999	$ (30)	$2,308	$ (58)	$6,307	$ (88)

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

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

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2017 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2017.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2017 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2017, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2017. There were no material other-than-temporary impairments in 2017, 2016, or 2015.

Goodwill and Long-lived Assets

At December 31, 2017, goodwill and other long-lived assets represented 19% of total assets and 52% of total stockholders' equity, compared to 20% and 47%, respectively, at December 31, 2016.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2017 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our provider services reporting unit in our Healthcare Services segment. The provider services reporting unit, with $590 million of goodwill, would decline to less than 10% margin after factoring in a 100 basis point increase in the discount rate.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including

accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $2.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2017 or December 31, 2016.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2017. Our net unrealized position increased $226 million from a net unrealized loss position of $28 million at December 31, 2016 to a net unrealized gain position of $198 million at December 31, 2017. At December 31, 2017, we had gross unrealized losses of $88 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2017. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio’s cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.1 years as of December 31, 2017 and 4.4 years as of December 31, 2016. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $697 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2017 and 2016. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points once, and have changed by less than 100 basis points eight times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2017						
Investment income (a)	$(87)	$(83)	$(67)	$67	$134	$202
Interest expense (b)	2	2	2	(2)	(3)	(5)
Pretax	$(85)	$(81)	$(65)	$65	$131	$197
As of December 31, 2016						
Investment income (a)	$(49)	$(44)	$(36)	$53	$107	$162
Interest expense (b)	3	3	3	(2)	(5)	(9)
Pretax	$(46)	$(41)	$(33)	$51	$102	$153

(a) As of December 31, 2017 and 2016, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2017 or December 31, 2016. There was $150 million outstanding under our commercial paper program at December 31, 2017. As of December 31, 2017, our interest rate under our commercial paper program was less than 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2017	2016
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$4,042	$3,877
Investment securities	9,557	7,595
Receivables, less allowance for doubtful accounts of $96 in 2017 and $118 in 2016	854	1,280
Other current assets	2,949	3,438
Total current assets	17,402	16,190
Property and equipment, net	1,584	1,505
Long-term investment securities	2,745	2,203
Goodwill	3,281	3,272
Other long-term assets	2,166	2,226
Total assets	$27,178	$25,396
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$4,668	$4,563
Trade accounts payable and accrued expenses	4,069	2,467
Book overdraft	141	212
Unearned revenues	378	280
Short-term borrowings	150	300
Total current liabilities	9,406	7,822
Long-term debt	4,770	3,792
Future policy benefits payable	2,923	2,834
Other long-term liabilities	237	263
Total liabilities	17,336	14,711
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,572,458 shares issued at December 31, 2017 and 198,495,007 shares issued at December 31, 2016	33	33
Capital in excess of par value	2,445	2,562
Retained earnings	13,670	11,454
Accumulated other comprehensive income (loss)	19	(66)
Treasury stock, at cost, 60,893,762 shares at December 31, 2017 and 49,189,811 shares at December 31, 2016	(6,325)	(3,298)
Total stockholders' equity	9,842	10,685
Total liabilities and stockholders' equity	$27,178	$25,396

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

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2017	2016	2015
	(in millions, except per share results)		
Revenues:			
Premiums	$52,380	$53,021	$52,409
Services	982	969	1,406
Investment income	405	389	474
Total revenues	53,767	54,379	54,289
Operating expenses:			
Benefits	43,496	45,007	44,269
Operating costs	6,567	7,173	7,295
Merger termination fee and related costs, net	(936)	104	23
Depreciation and amortization	378	354	355
Total operating expenses	49,505	52,638	51,942
Income from operations	4,262	1,741	2,347
Gain on sale of business	—	—	270
Interest expense	242	189	186
Income before income taxes	4,020	1,552	2,431
Provision for income taxes	1,572	938	1,155
Net income	$2,448	$614	$1,276
Basic earnings per common share	$16.94	$4.11	$8.54
Diluted earnings per common share	$16.81	$4.07	$8.44

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

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Net income	$2,448	$614	$1,276
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	149	(101)	(114)
Effect of income taxes	(55)	38	42
Total change in unrealized investment gains/losses, net of tax	94	(63)	(72)
Reclassification adjustment for net realized gains included in investment income	(14)	(96)	(146)
Effect of income taxes	5	35	53
Total reclassification adjustment, net of tax	(9)	(61)	(93)
Other comprehensive income (loss), net of tax	85	(124)	(165)
Comprehensive income	$2,533	$490	$1,111

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

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2015	197,952	$ 33	$ 2,330	$9,916	$ 223	$(2,856)	$ 9,646
Net income				1,276			1,276
Other comprehensive loss					(165)		(165)
Common stock repurchases			100			(485)	(385)
Dividends and dividend equivalents			—	(175)			(175)
Stock-based compensation			109				109
Restricted stock unit vesting	159	—	(49)			49	—
Stock option exercises	261	—	23				23
Stock option and restricted stock tax benefit			17				17
Balances, December 31, 2015	198,372	33	2,530	11,017	58	(3,292)	10,346
Net income				614			614
Other comprehensive loss					(124)		(124)
Common stock repurchases			—			(104)	(104)
Dividends and dividend equivalents			—	(177)			(177)
Stock-based compensation			115				115
Restricted stock unit vesting	13	—	(98)			98	—
Stock option exercises	110	—	13				13
Stock option and restricted stock tax benefit			2				2
Balances, December 31, 2016	198,495	33	2,562	11,454	(66)	(3,298)	10,685
Net income				2,448			2,448
Other comprehensive income					85		85
Common stock repurchases			(200)			(3,165)	(3,365)
Dividends and dividend equivalents			—	(232)			(232)
Stock-based compensation			157				157
Restricted stock unit vesting	—	—	(138)			138	—
Stock option exercises	77	—	64				64
Balances, December 31, 2017	198,572	$ 33	$ 2,445	$13,670	$ 19	$(6,325)	$ 9,842

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

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2017	2016	2015
	(in millions)		
Cash flows from operating activities			
Net income	$2,448	$614	$1,276
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of business	—	—	(270)
Depreciation	410	388	354
Amortization	75	77	93
Stock-based compensation	157	115	109
Net realized capital gains	(14)	(96)	(146)
Provision (benefit) for deferred income taxes	132	(71)	(2)
Provision for doubtful accounts	20	39	61
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	406	(158)	(180)
Other assets	(582)	426	(872)
Benefits payable	105	(413)	501
Other liabilities	641	937	(129)
Unearned revenues	98	(84)	3
Other	155	162	70
Net cash provided by operating activities	4,051	1,936	868
Cash flows from investing activities			
Acquisitions, net of cash acquired	(31)	(7)	(38)
Proceeds from sale of business	—	—	1,061
Purchases of property and equipment	(526)	(527)	(523)
Proceeds from sales of property and equipment	2	—	1
Purchases of investment securities	(6,265)	(6,566)	(6,739)
Maturities of investment securities	1,111	1,426	1,065
Proceeds from sales of investment securities	2,768	4,312	5,493
Net cash (used in) provided by investing activities	(2,941)	(1,362)	320
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	1,823	1,093	(296)
Proceeds from issuance of senior notes, net	1,779	—	—
(Repayments) proceeds from issuance of commercial paper, net	(153)	(2)	298
Repayment of long-term debt	(800)	—	—
Common stock repurchases	(3,365)	(104)	(385)
Dividends paid	(220)	(177)	(172)
Excess tax benefit from stock-based compensation	—	—	15
Change in book overdraft	(71)	(89)	(33)

Proceeds from stock option exercises and other, net	62	11	21
Net cash (used in) provided by financing activities	(945)	732	(552)
Increase in cash and cash equivalents	165	1,306	636
Cash and cash equivalents at beginning of year	3,877	2,571	1,935
Cash and cash equivalents at end of year	$4,042	$3,877	$2,571
Supplemental cash flow disclosures:			
Interest payments	$216	$185	$187
Income tax payments, net	$1,498	$916	$1,179
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$31	$7	$38
Less: Fair value of liabilities assumed	—	—	—
Cash paid for acquired businesses, net of cash acquired	$31	$7	$38

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

Humana Inc.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large. To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools, such as in home care, behavioral health, pharmacy services, data analytics and wellness solutions, combine to produce a simplified experience that makes health care easier to navigate and more effective. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 79% of our total premiums and services revenue from contracts with the federal government in 2017, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

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

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

Acquisition of a 40% Minority Interest in Kindred's Homecare Business

On December 19, 2017, we announced that we have entered into a definitive agreement to acquire a 40% minority interest in the Kindred at Home Division (Kindred at Home) of Kindred Healthcare, Inc. (Kindred)(NYSE: KND), the nation's largest home health provider and second largest hospice operator, for estimated cash consideration of approximately $800 million, including our share of transaction and related expenses, to facilitate a complete separation from the Long Term Acute Care and Rehabilitation businesses (the Specialty Hospital company). TPG Capital (TPG) and Welsh, Carson, Anderson & Stowe (WCAS), two private equity funds, collectively, the Sponsors, along with us are jointly creating a consortium to purchase all of the outstanding and issued securities of Kindred

Healthcare, Inc. Immediately following the closing of that transaction, Kindred at Home and the Specialty Hospital company will be separated, with the result being that the Specialty Hospital Company will be owned by the Sponsors and Kindred at Home will be owned by a joint venture owned by the Sponsors and us. We will own 40% of Kindred at Home, with the remaining 60% owned by a new entity owned by TPG and WCAS.

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

At the closing of the transaction, we will enter a shareholders agreement with the Sponsors that will provide for certain rights and obligations of each party concerning the newly formed joint venture that will own Kindred at Home. The shareholders agreement with the Sponsors includes a put option under which they have the right to require us to purchase their interest in the joint venture starting at the end of year three and ending at the end of year four following the closing. Consideration upon exercise of the put option per the agreement would be valued at an exit multiple of 10.5 times the preceding twelve months earnings before interest, income taxes, depreciation and amortization, or EBITDA, subject to certain adjustments. In addition, the multiple is subject to adjustment up to 11.5 times EBITDA based on the achievement of certain pre-defined value-based outcomes tied to clinical metrics. The 11.5 times EBITDA exit multiple is comparable to the valuation of our acquired interest in Kindred at Home. Finally, we have a call option under which we have the right to require the Sponsors to sell their interest in the joint venture to Humana beginning at the end of year four and ending at the end of year five following the closing for cash consideration using the same valuation methodology applicable to the previously discussed put option consideration.

The above transactions, which are anticipated to close in the summer of 2018, are subject to customary state and federal regulatory approvals, including approval by the stockholders of Kindred and the expiration of the waiting period under the Hart-Scott-Rodino Antitrust Improvement Act of 1976, as amended, as well as other customary closing conditions. We expect to fund the transaction through the use of parent company cash and will account for the minority investment under the equity method. The pending transaction did not have a material impact to earnings in 2017.

Sale of Closed Block of Commercial Long-Term Care Insurance Business

On November 6, 2017, we entered into a definitive agreement to sell the stock of our wholly-owned subsidiary, KMG America Corporation, or KMG, to Continental General Insurance Company, or CGIC, a Texas-based insurance company wholly owned by HC2 Holdings, Inc., a diversified holding company. KMG's subsidiary, Kanawha Insurance Company, or KIC, includes our closed block of non-strategic commercial long-term care insurance policies. Based on the terms of the definitive agreement we expect to record a net loss associated with the sale of KMG of approximately $365 million. The estimated loss includes a pretax loss of approximately $780 million, offset by the expected tax benefit of approximately $415 million. We will fund the transaction with approximately $203 million of parent company cash contributed into KMG, subject to customary adjustments, in addition to the transfer of approximately $150 million of statutory capital with the sale, which together should be more than offset by the estimated $415 million cash savings associated with the expected tax treatment of the sale. The KMG transaction is anticipated to close by the third quarter of 2018 subject to customary closing conditions, including South Carolina Department of Insurance approval. There can be no assurance we will obtain regulatory approvals needed to sell the business or do so under terms acceptable to us.

Workforce Optimization

During 2017, we initiated a voluntary early retirement program and an involuntary workforce reduction program. These programs impacted approximately 3,600 associates, or 7.8% of our workforce. As a result, we recorded charges of $148 million, or $0.64 per diluted common share. These charges are included with operating costs in the consolidated statements of income for the year ended December 31, 2017 and are included at the corporate level in the segment financial information in Note 17. Payments under these programs are made upon termination during the early retirement or severance pay period, beginning in the first quarter of 2018. We expect this liability to be primarily paid within the next 12 months and classified it as a current liability, included in our consolidated balance sheet in the trade accounts payable and accrued expenses line.

Aetna Merger

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

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as

amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

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

On July 21, 2016, the U.S. Department of Justice, or DOJ, and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. On February 16, 2017, under the terms of the Merger Agreement, we received a breakup fee of $1 billion from Aetna, which is included in our consolidated statement of income in the line captioned Merger termination fee and related costs, net. Prior period Merger related transaction costs, previously included in operating costs, have been reclassified to conform to the 2017 presentation.

Business Segment Reclassifications

During the first quarter of 2017, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes corresponding to those used by our chief operating decision maker to evaluate results of operations and our previously announced planned exit from the Individual Commercial medical business on January 1, 2018. Additionally, we renamed our Group segment to the Group and Specialty segment, and began presenting the Individual Commercial business results as a separate segment rather than as part of the Retail segment. Specialty health insurance benefits, including dental, vision, other supplemental health, and financial protection products, marketed to individuals are now included in the Group and Specialty segment. Specialty health insurance benefits marketed to employer groups continue to be included in the Group and Specialty segment. As a result of this realignment, our reportable segments now include Retail, Group and Specialty, Healthcare Services, and Individual Commercial. Prior period segment financial information has been recast to conform to the 2017 presentation. See Note 17 for recast segment financial information.

Health Care Reform

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

The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. The Continuing Resolution bill, H.R. 195, enacted on January 22, 2018, included a one year suspension in 2019 of the health insurer fee, but the fee is scheduled to resume in calendar year 2020. See Note 7 for detail regarding amounts paid for the annual health insurer fee.

The Health Care Reform Law also established risk spreading premium stabilization programs effective January 1, 2014, with an annual open enrollment period. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately

13% of our total premiums and services revenue for the year ended December 31, 2017, a subset of which is subject to these programs. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Effective January 1, 2018, we have exited our Individual Commercial medical business. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law. We refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits.

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

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant

funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, and ceased recognizing revenues under the risk corridor program as discussed further in Note 7.

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

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

In addition to the provisions discussed above, beginning in 2014, HHS paid us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. These cost subsidy payments ceased effective October 2017. We accounted for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We did not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity was accumulated at the state and legal entity level and recorded in our consolidated balance sheet in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the coverage year. For 2017, payments to HHS associated with cost sharing subsidies for which we did not assume risk were approximately $76 million, exceeding receipts of $32 million by $44 million. For 2016, payments to HHS associated with cost sharing subsidies for which we did not assume risk were approximately $373 million, exceeding receipts of $345 million by $28 million. For 2015, receipts from HHS associated with cost sharing subsidies for which we did not assume risk were approximately $478 million, exceeding payments of $409 million by $69 million.

Cash and Cash Equivalents

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

Investment Securities

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

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

only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

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

Premiums Revenue

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

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

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

Medicare Part D

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

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

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2017, subsidy and discount reimbursements of $12.1 billion exceeded payments of $10.2 billion by $1.9 billion. For 2016, subsidy and discount reimbursements of $11.1 billion exceeded payments of $10.0 billion by $1.1 billion. For 2015, subsidy and discount payments of $8.9 billion exceeded reimbursements of $8.6 billion by $361 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

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

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to employer needs or as required by law. Patient services revenues are recognized in the period services are provided to

the customer when the sales price is fixed or determinable, and are net of contractual allowances.

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

Administrative services fees

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

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

Our TRICARE members are served by both in-network and out-of-network providers in accordance with our contracts. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government’s claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2017, health care cost reimbursements and payments were each approximately $3.4 billion, with reimbursements exceeding payments by $11 million for the year. For 2016, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $25 million for the year. For 2015, health care cost reimbursements and payments were each approximately $3.3 billion with payments exceeding reimbursements by $4 million for the year.

Receivables

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

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 6, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates receivable was $1.2 billion at December 31, 2017 and $889 million at December 31, 2016.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies

typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Life insurance, annuities, and certain health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As

a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

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

Long-Lived Assets

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

We periodically review long-lived assets, including property and equipment and other intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Goodwill and Other Intangible Assets

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

As discussed further below, we early adopted the Financial Accounting Standards Board, or FASB, issued guidance simplifying the accounting for goodwill impairment. We use the one-step process to review goodwill for impairment to determine both the existence and amount of goodwill impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2017, 2016, and 2015 did not result in an impairment loss.

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

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well

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

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

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

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

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

submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required. Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of

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

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In the fourth quarter of 2015, we recognized a premium deficiency reserve of $176 million for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year and recorded a change in estimate of $208 million in the second quarter of 2016 associated with the 2016 coverage year as discussed in more detail in Note 7. As of December 31, 2016 and December 31, 2017, we had no remaining premium deficiency reserve.

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

Future policy benefits payable

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

We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed previously,

beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the release of reserves for future policy benefits.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Book Overdraft

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

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

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

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida and Texas. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us beginning in 2018 as well as a call option that would allow us to purchase the controlling interest beginning in 2021. Accordingly, we recorded the effects of the put and call option at fair value. Changes in the fair values during the years ended December 31, 2017, 2016, and 2015 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2017, 2016, or 2015.

Related Party

As noted above, MCCI is a related party to Humana. In December 2015, we purchased a note receivable directly from a third-party bank syndicate related to the financing of MCCI's business and extended the exercise date of the put option to 2018 and the call option to 2021. The note receivable balance was $349 million and $314 million at December 31, 2017 and 2016, respectively, and was included with other long-term assets in our consolidated balance sheets. The note receivable bears interest at 10% annually, payable in quarterly installments, and matures in December 2020. We have also entered into a revolving note agreement providing a line of credit up to $55 million under which $18 million was outstanding at December 31, 2017, and we had no balance outstanding at December 31, 2016. The 2015 note purchase is included with purchases of investment securities in our consolidated statements of cash flows. The related interest income of $35 million and $30 million for 2017 and 2016, respectively, is included in investment income in our consolidated statements of income. The interest was accrued to the loan balance during 2017 and 2016 pursuant to the terms of the note. MCCI provides services to Humana Medicare Advantage members under capitation contracts with our health plans. Under these capitation agreements with Humana, MCCI assumes the financial risk associated with these Medicare Advantage members. We also have an outstanding advance to MCCI of approximately

$3 million and $6 million at December 31, 2017 and 2016, respectively, with repayment terms tied to the performance

under the capitation agreements. We recognized benefits expense of approximately $1.1 billion in 2017, $1.1 billion in 2016 and $1.0 billion in 2015 under these capitation agreements with MCCI.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. However, prior to July 2, 2015, for awards granted to retirement eligible employees, compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. For awards granted on or after July 2, 2015 to retirement eligible employees, we recognize expense on a straight-line basis over the service period (the vesting period). We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model. Prior to 2016 we reported certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. In 2016, we prospectively applied the provisions of new guidance issued by the FASB related to the presentation of windfall tax benefits as cash flows from operating activities which resulted in reclassifying $20 million of cash flows from financing activities to operating activities for the three months ended March 31, 2016. We estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period.

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

Earnings Per Common Share

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

Fair Value

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

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates

generally using a market valuation approach, or, less frequently, an income valuation approach and are generally

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

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

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In January 2017, the FASB issued guidance which simplifies the accounting for goodwill impairment. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. A goodwill impairment charge would be recognized if the carrying amount of a reporting unit exceeds the estimated fair value of the reporting unit. The new guidance is effective beginning with annual and interim periods in 2020, with early adoption permitted, and is to be applied prospectively. We early adopted this new guidance in the fourth quarter of 2017 and it did not have an impact on our results of operations, financial condition, or cash flows.

Accounting Pronouncements Effective in Future Periods

In March 2017, the FASB issued new guidance that amends the accounting for premium amortization on purchased callable debt securities by shortening the amortization period. This amended guidance requires the premium to be amortized to the earliest call date instead of maturity date. The new guidance is effective for us beginning with annual and interim periods in 2019. We do not expect adoption of this guidance will have a material impact on our results of operations, financial condition and cash flows.

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance is effective for us beginning January 1, 2020. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as

reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio consists of available-for-sale debt securities. We are currently evaluating the impact on our results of operations, financial condition, or cash flows.

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

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

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. Accordingly, our premiums revenue and investment income, collectively representing approximately 98% of our consolidated external revenues for 2017, are not included in the scope of the new guidance. We adopted the new standard effective January 1, 2018, as allowed, using the modified retrospective approach. As the majority of or revenues are not subject to the new guidance and the remaining revenues' accounting treatment did not materially differ from existing accounting treatment, the adoption of the new standard did not have a material impact on our consolidated results of operations, financial condition, cash flows, and disclosures.

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

3. ACQUISITIONS AND DIVESTITURES

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

During 2017, 2016 and 2015, we acquired health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our consolidated statements of income and consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2017, 2016, and 2015 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

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

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2017 and 2016, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
	(in millions)			
December 31, 2017				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$532	$ 1	$ (2)	$531
Mortgage-backed securities	1,625	4	(19)	1,610
Tax-exempt municipal securities	3,884	33	(28)	3,889
Mortgage-backed securities:				
Residential	26	—	—	26
Commercial	455	3	(2)	456
Asset-backed securities	407	1	—	408
Corporate debt securities	5,175	244	(37)	5,382
Total debt securities	$12,104	$ 286	$ (88)	$12,302
December 31, 2016				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$800	$ 1	$ (15)	$786
Mortgage-backed securities	1,662	6	(31)	1,637
Tax-exempt municipal securities	3,358	15	(68)	3,305
Mortgage-backed securities:				
Residential	9	—	—	9
Commercial	307	1	(4)	304
Asset-backed securities	160	—	—	160
Corporate debt securities	3,530	145	(78)	3,597
Total debt securities	$9,826	$ 168	$ (196)	$9,798

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

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2017 and 2016, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2017						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$273	$ (1)	$130	$ (1)	$403	$ (2)
Mortgage-backed securities	581	(2)	672	(17)	1,253	(19)
Tax-exempt municipal securities	1,590	(16)	661	(12)	2,251	(28)
Mortgage-backed securities:						
Residential	20	—	3	—	23	—
Commercial	131	(1)	28	(1)	159	(2)
Asset-backed securities	107	—	10	—	117	—
Corporate debt securities	1,297	(10)	804	(27)	2,101	(37)
Total debt securities	$3,999	$ (30)	$2,308	$ (58)	$6,307	$ (88)
December 31, 2016						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$697	$ (15)	$3	$ —	$700	$ (15)
Mortgage-backed securities	1,528	(31)	3	—	1,531	(31)
Tax-exempt municipal securities	2,756	(67)	43	(1)	2,799	(68)
Mortgage-backed securities:						
Residential	—	—	4	—	4	—
Commercial	182	(3)	24	(1)	206	(4)
Asset-backed securities	51	—	63	—	114	—
Corporate debt securities	1,544	(71)	69	(7)	1,613	(78)
Total debt securities	$6,758	$ (187)	$209	$ (9)	$6,967	$ (196)

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2017. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2017, 6% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 49% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 51% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 9%. In addition, 2% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

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

Residential mortgage back securities comprised approximately 93% of our agency mortgage-backed securities at December 31, 2017 and 99% at December 31, 2016.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2017 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2017.

The percentage of corporate securities associated with the financial services industry was 30% at December 31, 2017 and 23% at December 31, 2016.

Our unrealized loss from all securities was generated from approximately 900 positions out of a total of approximately 2,410 positions at December 31, 2017. All issuers of securities we own that were trading at an unrealized loss at December 31, 2017 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2017, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2017.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2017, 2016, and 2015:

	2017	2016	2015
	(in millions)		
Gross realized gains	$35	$120	$179
Gross realized losses	(21)	(24)	(33)
Net realized capital gains	$14	$96	$146

There were no material other-than-temporary impairments in 2017, 2016, or 2015.

The contractual maturities of debt securities available for sale at December 31, 2017, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$712	$711
Due after one year through five years	2,872	2,867
Due after five years through ten years	2,661	2,657
Due after ten years	3,346	3,567
Mortgage and asset-backed securities	2,513	2,500
Total debt securities	$12,104	$12,302

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2017 and 2016, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
	(in millions)			
December 31, 2017				
Cash equivalents	$4,564	$4,564	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	531	—	531	—
Mortgage-backed securities	1,610	—	1,610	—
Tax-exempt municipal securities	3,889	—	3,889	—
Mortgage-backed securities:				
Residential	26	—	26	—
Commercial	456	—	456	—
Asset-backed securities	408	—	408	—
Corporate debt securities	5,382	—	5,381	1
Total debt securities	12,302	—	12,301	1
Total invested assets	$16,866	$4,564	$ 12,301	$ 1
December 31, 2016				
Cash equivalents	$3,654	$3,654	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	786	—	786	—
Mortgage-backed securities	1,637	—	1,637	—
Tax-exempt municipal securities	3,305	—	3,302	3
Mortgage-backed securities:				
Residential	9	—	9	—
Commercial	304	—	304	—
Asset-backed securities	160	—	160	—
Corporate debt securities	3,597	—	3,593	4
Total debt securities	9,798	—	9,791	7
Total invested assets	$13,452	$3,654	$ 9,791	$ 7

There were no material transfers between Level 1 and Level 2 during 2017 or 2016.

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

Our Level 3 assets had a fair value of $1 million at December 31, 2017, or less than 0.1% of our total invested assets. During the years ended December 31, 2017, 2016, and 2015, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2017			2016			2015		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$4	$ 3	$ 7	$6	$ 5	$11	$24	$ 8	$32
Total gains or losses:									
Realized in earnings	—	—	—	—	—	—	(1)	—	(1)
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	(3)	—	(3)	—	—	—	(17)	(3)	(20)
Settlements	—	(3)	(3)	(2)	(2)	(4)	—	—	—
Balance at December 31	$1	$ —	$ 1	$4	$ 3	$7	$6	$ 5	$11

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $4,770 million at December 31, 2017 and $3,792 million at December 31, 2016. The fair value of our long-term debt was $5,191 million at December 31, 2017 and $4,004 million at December 31, 2016. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for our commercial paper borrowings. There were outstanding commercial paper borrowings of $150 million outstanding at December 31, 2017, compared to $300 million outstanding at December 31, 2016.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisitions of certain health and wellness related businesses during 2017, 2016, and 2015. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2017, 2016, or 2015.

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6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2017 and 2016. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2017		2016	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$4	$ 101	$8	$ 1,001
Trade accounts payable and accrued expenses	(255)	(1,085)	(158)	(128)
Net current (liability) asset	(251)	(984)	(150)	$ 873
Other long-term liabilities	(28)	—	—	—
Total net (liability) asset	$(279)	$ (984)	$(150)	$ 873

7. HEALTH CARE REFORM

We have exited our individual commercial medical business effective January 1, 2018. Operating results for our individual commercial medical business compliant with the Health Care Reform Law were challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 that we believed would improve the profitability of our individual commercial medical business in 2016. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results that included the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment in the fourth quarter of 2015 of the profitability of our individual commercial medical policies compliant with the Health Care Reform Law, we recorded in that quarter a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million in benefits payable in our consolidated balance sheet with a corresponding increase in benefits expense in our consolidated statement of income. In the second quarter of 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense in our consolidated statement of income. During 2016, $384 million current period losses were applied to the premium deficiency reserve liability for the 2016 coverage year. At December 31, 2017 and 2016, we had no premium deficiency reserve.

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2017, we collected approximately $39 million from CMS for risk corridor receivables associated with

the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. On November 2, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, on behalf of our health plans seeking recovery from the federal government of approximately $611 million in payments under the risk corridor premium stabilization program established under the Health Care Reform Law, for years 2014, 2015 and 2016.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2017 and December 31, 2016.

	2017			2016		
	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
	(in millions)					
Prior Coverage Years						
Premiums receivable	$—	$ —	$ —	$ 307	$ —	$ —
Other current assets	—	44	—	—	260	—
Trade accounts payable and accrued expenses	—	—	—	(117)	—	—
Net current asset	—	44	—	190	260	—
Other long-term assets	—	—	—	6	—	—
Total prior coverage years' net asset	—	44	—	196	260	—
Current Coverage Year						
Premiums receivable	62	—	—	—	—	—
Trade accounts payable and accrued expenses	(80)	—	—	—	—	—
Net current liability	(18)	—	—	—	—	—
Other long-term assets	5	—	—	—	—	—
Total prior coverage years' net liability	(13)	—	—	—	—	—
Total net (liability) asset	$ (13)	$ 44	$ —	$ 196	$ 260	$ —

Net collections under the 3Rs associated with prior coverage years were $440 million during 2017 and were $383 million during 2016. We expect to collect the remaining $44 million of reinsurance recoverables related to prior coverage years in 2018.

The annual health insurance industry fee was suspended for calendar year 2017, but has resumed for calendar year 2018. In 2016, we paid the federal government $916 million for the annual health insurance industry fee attributed to calendar year 2016, compared to $867 million in 2015, in accordance with the Health Care Reform Law. This fee is not deductible for tax purposes. The annual health insurance industry fee was also suspended for the calendar year 2019 and is scheduled to resume in calendar year 2020.

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8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2017 and 2016.

	2017	2016
	(in millions)	
Land	$20	$20
Buildings and leasehold improvements	713	681
Equipment	824	750
Computer software	2,003	1,744
	3,560	3,195
Accumulated depreciation	(1,976)	(1,690)
Property and equipment, net	$1,584	$1,505

Depreciation expense was $410 million in 2017, $388 million in 2016, and $354 million in 2015, including amortization expense for capitalized internally developed and purchased software of $287 million in 2017, $255 million in 2016, and $220 million in 2015.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2017 segment reclassification as discussed in Note 1. Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2017 and 2016 were as follows:

	Retail	Group and Specialty	Healthcare Services	Total
	(in millions)			
Balance at January 1, 2016	$1,059	$ 261	$ 1,945	$3,265
Acquisitions	—	—	7	7
Balance at December 31, 2016	1,059	261	1,952	3,272
Acquisitions	—	—	9	9
Balance at December 31, 2017	$1,059	$ 261	$ 1,961	$3,281

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2017 and 2016.

	Weighted Average Life	2017			2016		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
		(in millions)					
Other intangible assets:							
Customer contracts/relationships	9.8 years	$566	$ 401	$165	$566	$ 347	$219
Trade names and technology	8.2 years	104	84	20	104	69	35
Provider contracts	11.9 years	68	30	38	51	29	22
Noncompetes and other	8.1 years	32	29	3	32	28	4
Total other intangible assets	9.7 years	$770	$ 544	$226	$753	$ 473	$280

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Amortization expense for other intangible assets was approximately $75 million in 2017, $77 million in 2016, and $93 million in 2015. The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2018	$ 64
2019	54
2020	52
2021	19
2022	16

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10. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Balances at January 1	$4,563	$4,976	$4,475
Less: Premium deficiency reserve	—	(176)	—
Less: Reinsurance recoverables	(76)	(85)	(78)
Balances at January 1, net	4,487	4,715	4,397
Incurred related to:			
Current year	44,001	45,318	44,397
Prior years	(483)	(582)	(236)
Total incurred	43,518	44,736	44,161
Paid related to:			
Current year	(39,496)	(40,852)	(39,802)
Prior years	(3,911)	(4,112)	(4,041)
Total paid	(43,407)	(44,964)	(43,843)
Premium deficiency reserve	—	—	176
Reinsurance recoverable	70	76	85
Balances at December 31	$4,668	$4,563	$4,976

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

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $483 million in 2017, $582 million in 2016, and $236 million in 2015. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2017, 2016, and 2015.

	Favorable Medical Claims Reserve Development		
	2017	2016	2015
Retail Segment	$ (386)	$ (429)	$ (248)
Group and Specialty Segment	(40)	(46)	(7)
Individual Commercial Segment	(56)	(106)	20
Other Businesses	(1)	(1)	(1)
Total	$ (483)	$ (582)	$ (236)

The favorable medical claims reserve development for 2017, 2016, and 2015 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development in 2017 and 2016 primarily resulted from our Medicare Advantage and individual commercial medical businesses. The favorable prior period development in 2015 was impacted primarily by lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission

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as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Premium deficiency reserve for short-duration policies	$—	$(176)	$176
Military services	—	8	12
Future policy benefits	(22)	439	(80)
Total	$(22)	$271	$108

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

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

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

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our segments as of December 31, 2017, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2015 and 2016 is presented as supplementary information.

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

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Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Balances at January 1	$3,506	$3,600	$3,428
Less: Reinsurance recoverables	(76)	(85)	(78)
Balances at January 1, net	3,430	3,515	3,350
Incurred related to:			
Current year	38,604	37,212	36,299
Prior years	(386)	(429)	(248)
Total incurred	38,218	36,783	36,051
Paid related to:			
Current year	(34,781)	(33,784)	(32,874)
Prior years	(2,974)	(3,084)	(3,012)
Total paid	(37,755)	(36,868)	(35,886)
Reinsurance recoverable	70	76	85
Balances at December 31	$3,963	$3,506	$3,600

At December 31, 2017, benefits payable for our Retail segment included IBNR of approximately $2.5 billion, primarily associated with claims incurred in 2017. The cumulative number of reported claims as of December 31, 2017 was approximately 97.8 million for claims incurred in 2017, 96.0 million for claims incurred in 2016, and 93.9 million for claims incurred in 2015.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2017, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$36,299	$ 35,928	$35,877
2016		37,212	36,891
2017			38,604
Total			$111,372

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	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$32,874	$ 35,918	$35,857
2016		33,784	36,841
2017			34,781
Total			$107,479
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$3,893

Group and Specialty Segment

Activity in benefits payable for our Group and Specialty segment, excluding military services, was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Balances at January 1	$579	$616	$603
Less: Reinsurance recoverables	—	—	—
Balances at January 1, net	579	616	603
Incurred related to:			
Current year	5,403	5,271	5,377
Prior years	(40)	(46)	(7)
Total incurred	5,363	5,225	5,370
Paid related to:			
Current year	(4,843)	(4,700)	(4,774)
Prior years	(531)	(562)	(583)
Total paid	(5,374)	(5,262)	(5,357)
Balances at December 31	$568	$579	$616

At December 31, 2017, benefits payable for our Group and Specialty segment included IBNR of approximately $500 million, primarily associated with claims incurred in 2017. The cumulative number of reported claims as of December 31, 2017 was approximately 10.6 million for claims incurred in 2017, 12.8 million for claims incurred in 2016, and 13.4 million for claims incurred in 2015.

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The following tables provide information about incurred and paid claims development for the Group and Specialty segment as of December 31, 2017, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$5,377	$ 5,333	$5,333
2016		5,271	5,234
2017			5,403
Total			$15,970

	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
	(in millions)		
2015	$4,774	$ 5,327	$5,333
2016		4,700	5,226
2017			4,843
Total			$15,402
All outstanding benefit liabilities before 2015, net of reinsurance			N/A
Benefits payable, net of reinsurance			$568

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Individual Commercial Segment

Activity in benefits payable for our Individual Commercial segment, was as follows for the years ended December 31, 2017, 2016 and 2015:

	2017	2016	2015
	(in millions)		
Balances at January 1	$454	$741	$424
Less: Premium deficiency reserve	—	(176)	—
Balances at January 1, net	454	565	424
Incurred related to:			
Current year	669	3,677	3,512
Prior years	(56)	(106)	20
Total incurred	613	3,571	3,532
Paid related to:			
Current year	(583)	(3,233)	(2,966)
Prior years	(383)	(449)	(425)
Total paid	(966)	(3,682)	(3,391)
Premium deficiency reserve	—	—	176
Balances at December 31	$101	$454	$741

At December 31, 2017, benefits payable for our Individual Commercial segment included IBNR of approximately $85 million, primarily associated with claims incurred in 2017. The cumulative number of reported claims as of December 31, 2017 was approximately 2.2 million for claims incurred in 2017, 9.5 million for claims incurred in 2016, and 11.0 million for claims incurred in 2015.

The following tables provide information about incurred and paid claims development for the Individual Commercial segment as of December 31, 2017, net of reinsurance.

	Incurred Claims, Net of Reinsurance For the Years Ended December 31,		
Claims Incurred Year	2015 Unaudited	2016 Unaudited	2017
2015	$3,512	$ 3,412	$3,412
2016		3,677	3,621
2017			669
Total			$7,702

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Cumulative Paid Claims, Net of Reinsurance