HUMANA INC
Form 10-K
February 18, 2016
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, 2015
OR

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

For the transition period from to
Commission file number 1-5975
HUMANA INC.
(Exact name of registrant as specified in its charter)

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

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

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

Securities registered pursuant to Section 12(g) of the Act:
None
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes þ No ¨
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No þ
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes þ No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. þ
Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):
Large accelerated filer þ Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No þ
The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2015 was $28,626,230,036 calculated using the average price on June 30, 2015 of $193.67.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2016 was 148,303,389.

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 21, 2016.

HUMANA INC.
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For the Year Ended December 31, 2015

Forward-Looking Statements

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

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as “we,” “us,” “our,” the “Company” or “Humana,” is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. As of December 31, 2015, we had approximately 14.2 million members in our medical benefit plans, as well as approximately 7.2 million members in our specialty products. During 2015, 73% of our total premiums and services revenue were derived from contracts with the federal government, including 14% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 587,400 members as of December 31, 2015.

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 2015 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2015 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 will merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. Under the terms of the Merger Agreement, at the closing of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash. The total transaction was estimated at approximately $37 billion including the assumption of Humana debt, based on the closing price of Aetna common shares on July 2, 2015. The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger,

generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

On October 19, 2015, our stockholders approved the adoption of the Merger Agreement at a special stockholder meeting. Also on October 19, 2015, the holders of Aetna outstanding shares approved the issuance of Aetna common stock in the Merger at a special meeting of Aetna shareholders.

The Merger is 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, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect to our Medicare Advantage, or MA, business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and our subsidiaries, taken as a whole. The Merger is currently expected to close in the second half of 2016.

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 2015 Form 10-K.

Business Segments

On January 1, 2015, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes and renamed our Employer Group segment to the Group segment. Our three reportable segments remain Retail, Group, and Healthcare Services. The more significant realignments included reclassifying Medicare benefits offered to groups to the Retail segment from the Group segment, bringing all of our Medicare offerings, which are now managed collectively, together in one segment, recognizing that in some instances we market directly to individuals that are part of a group Medicare account. In addition, we realigned our military services business, primarily consisting of our TRICARE South Region contract previously included in the Other Businesses category, to our Group segment as we consider this contract with the government to be a group account. Prior period segment financial information has been recast to conform to the 2015 presentation. See Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data in this 2015 Form 10-K for segment financial information.

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

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, home based, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2015:

	Retail Segment Premiums and Services Revenue (dollars in millions)	Percent of Consolidated Premiums and Services Revenue	
Premiums:			
Individual Medicare Advantage	$29,526	54.9	%
Group Medicare Advantage	5,588	10.4	%
Medicare stand-alone PDP	3,846	7.1	%
Total Medicare	38,960	72.4	%
Individual commercial	4,243	7.9	%
State-based Medicaid	2,341	4.3	%
Individual specialty	261	0.5	%
Total premiums	45,805	85.1	%
Services	9	—	%
Total premiums and services revenue	$45,814	85.1	%

Medicare

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

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

Individual Medicare Advantage Products

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

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

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

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines.

At December 31, 2015, we provided health insurance coverage under CMS contracts to approximately 2,753,400 individual Medicare Advantage members, including approximately 587,400 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.8 billion, which represented approximately 26.3% of our individual Medicare Advantage premiums revenue, or 14.5% of our consolidated premiums and services revenue for the year ended December 31, 2015.

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 2016, and all of our product offerings filed with CMS for 2016 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2016, and all of our product offerings filed with CMS for 2016 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 American Eldercare Inc., or American Eldercare, acquisition in 2013 expanded our LTSS footprint in Florida. Our contracts are generally for three to five year terms.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. There were approximately 10.2 million dual eligible individuals in the United States in 2015, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and LTSS benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs.

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

In addition to the dual eligible members we serve under the Virginia and Illinois demonstration program, we serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans. As of December 31, 2015, we served approximately 440,000 dual eligible members in our Medicare Advantage plans and approximately 1,070,000 dual eligible members in our stand-alone prescription drug plans.

Individual Commercial Coverage

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

Prior to 2014, our HumanaOne® plans primarily were offered as PPO plans where we could generally underwrite risk and utilize our existing networks and distribution channels.

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

Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans as well as health and wellness products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group segment by product for the year ended December 31, 2015:

	Group Segment Premiums and Services Revenue (dollars in millions)	Percent of Consolidated Premiums and Services Revenue	
External Revenue:			
Premiums:			
Fully-insured commercial group	$5,493	10.2	%
Group specialty	1,055	2.0	%
Military services	21	—	%
Total premiums	6,569	12.2	%
Services	698	1.3	%
Total premiums and services revenue	$7,267	13.5	%
Intersegment services revenue:			
Wellness	$93	n/a	
Total intersegment services revenue	$93		

n/a – not applicable

Group Commercial Coverage

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

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

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

Military Services

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

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

Wellness

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

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

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, home based services, clinical programs, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2015:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue	
	(dollars in millions)		
Intersegment revenue:			
Pharmacy solutions	$20,551	n/a	
Provider services	1,291	n/a	
Home based services	875	n/a	
Clinical programs	203	n/a	
Total intersegment revenue	$22,920		
External services revenue:			
Provider services	$515	0.9	%
Home based services	140	0.3	%
Pharmacy solutions	30	0.1	%
Total external services revenue	$685	1.3	%

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

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

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, that delivered occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities.

Home based services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Home based services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home® is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. To that end, we have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2015, we enrolled approximately 590,300 members with complex chronic conditions in the Humana Chronic Care Program, a 40.3% increase compared with approximately 420,700 members at December 31, 2014, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Clinical programs

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

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

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

Other Businesses

Other Businesses primarily includes our closed block of long-term care insurance policies described below. Total premiums and services revenue for our Other Businesses was $49 million, or 0.1% of consolidated premiums and services revenue for the year ended December 31, 2015.

We have a non-strategic closed block of approximately 31,800 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

Membership

The following table summarizes our total medical membership at December 31, 2015, by market and product:

	Retail Segment (in thousands)					Group Segment					
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Individual Commercial	State-based contracts	Fully-insured commercial Group	ASO	Military services	Other Businesses	Total	Percent of Total
Florida	587.4	19.9	320.5	288.4	351.9	168.4	33.8	—	—	1,770.3	12.5 %
Texas	215.6	68.8	281.4	163.8	—	217.3	107.2	—	—	1,054.1	7.4 %
Georgia	105.2	2.5	115.0	270.2	—	155.3	18.6	—	—	666.8	4.7 %
Kentucky	69.9	56.1	203.8	17.6	—	109.3	195.5	—	—	652.2	4.6 %
Ohio	105.8	155.6	143.5	20.8	—	46.3	70.1	—	—	542.1	3.8 %
California	64.9	0.1	420.7	13.3	—	—	—	—	—	499.0	3.5 %
Illinois	81.7	20.8	154.1	11.3	12.0	82.4	95.0	—	—	457.3	3.2 %
Missouri/Kansas	100.6	3.4	202.0	18.7	—	52.9	9.4	—	—	387.0	2.7 %
Tennessee	139.8	2.0	97.5	26.5	—	47.0	34.9	—	—	347.7	2.5 %
Wisconsin	63.2	10.1	95.8	8.5	—	84.2	80.1	—	—	341.9	2.4 %
Louisiana	147.2	10.9	54.4	20.6	—	67.9	31.7	—	—	332.7	2.3 %
North Carolina	129.4	37.2	158.4	5.6	—	—	—	—	—	330.6	2.3 %
Indiana	88.1	3.7	120.2	12.1	—	22.4	17.2	—	—	263.7	1.9 %
Virginia	111.2	5.5	125.5	8.9	9.8	—	—	—	—	260.9	1.8 %
Michigan	48.8	14.1	135.8	19.4	—	6.5	0.5	—	—	225.1	1.6 %
Colorado	35.2	5.5	83.3	22.7	—	24.8	1.1	—	—	172.6	1.2 %
Arizona	57.8	1.2	75.3	8.4	—	28.4	1.2	—	—	172.3	1.2 %
Military services	—	—	—	—	—	—	—	3,074.4	—	3,074.4	21.6 %
Others	601.6	66.7	1,770.7	120.9	—	65.2	14.4	—	32.6	2,672.1	18.8 %
Totals	2,753.4	484.1	4,557.9	1,057.7	373.7	1,178.3	710.7	3,074.4	32.6	14,222.8	100.0 %

Provider Arrangements

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

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

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

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

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

Automatic reductions to the federal budget, known as sequestration, took effect on April 1, 2013, including aggregate reductions to Medicare payments to providers of up to 2% per fiscal year. Due to the uncertainty around the application of these reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs. See “Legal Proceedings and Certain Regulatory Matters” in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

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, 2015, approximately 1,100,000 members, or 7.7% of our medical membership, were covered under risk-based contracts, including 863,000 individual Medicare Advantage members, or 31.3% 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 196,600 HMO members, including 172,000 individual Medicare Advantage members, or 19.9% of the 863,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2015, 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 $768 million, or 1.7% of total benefits expense, for the year ended December 31, 2015. 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, 2015, we employed approximately 1,600 sales representatives, as well as approximately 1,400 telemarketing representatives who assisted in the marketing of Medicare and individual commercial health insurance and specialty products in our Retail segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. In addition, we have begun to offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange. There, 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

Beginning in 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 in 2014 and beyond. 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.

Prior to 2014, through the use of internally developed underwriting criteria, we determined the risk we were willing to assume and the amount of premium to charge for our commercial products. In most instances, employer and other groups had to meet our underwriting standards in order to qualify to contract with us for coverage.

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 2015 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 2015 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, 2015, we had approximately 50,100 employees and approximately 1,600 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to the Merger with Aetna

The merger with Aetna is subject to various closing conditions, including governmental and regulatory approvals as well as other uncertainties and there can be no assurances as to whether and when it may be completed.

On July 2, 2015, we entered into an Agreement and Plan of Merger (which we refer to as the "Merger Agreement"), with Aetna Inc. (or "Aetna"), Echo Merger Sub, Inc. (or "Sub 1") and Echo Merger Sub, LLC (or "Sub 2"), each a wholly owned subsidiary of Aetna. Under the terms and subject to the conditions set forth in the Merger Agreement, Sub 1 will merge with and into us (the "Merger"). In the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash without interest, subject to any required withholding taxes. Immediately after the Merger, we (as the surviving corporation in the Merger) will be merged with and into Sub 2, with Sub 2 remaining as the surviving entity of that merger and as a wholly owned subsidiary of Aetna, to be renamed Humana LLC. The Merger is expected to close in the second half of 2016.

On October 19, 2015, at separate meetings, our stockholders approved the adoption of the Merger Agreement, and Aetna's shareholders approved the issuance of Aetna common stock in the Merger. Consummation of the Merger remains subject to other customary closing conditions, however, a number of which are not within our or Aetna's control, and it is possible that such conditions may prevent, delay or otherwise materially adversely affect the completion of the Merger. These conditions include, 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, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect to our Medicare Advantage business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and its subsidiaries, taken as a whole. We cannot predict with certainty whether and when any of the required closing conditions will be satisfied or if another uncertainty may arise.

If the Merger does not receive, or timely receive, the required regulatory approvals and clearances, or if any regulatory agencies impose certain conditions relating to the required regulatory approvals that would reasonably be expected to have a "Regulatory Material Adverse Effect", or if an event occurs that delays or prevents the Merger, such failure or delay to complete the Merger may cause uncertainty or other negative consequences that may materially and adversely affect our results of operations, financial position, cash flows and the price per share for our common stock.

The Merger Agreement prohibits us from pursuing alternative transactions to the Merger.

Following the receipt of approval by our stockholders and Aetna's shareholders (with respect to the Aetna stock to be issued in the transaction) on October 19, 2015, the Merger Agreement is binding on the parties, subject to customary closing conditions. The Merger Agreement prohibits us from initiating, soliciting, knowingly encouraging, knowingly facilitating or entering into discussions or negotiations with any third party regarding alternative acquisition proposals. This provision prevents us from affirmatively seeking offers from other possible acquirers that may be superior to the pending Merger. We do not have the ability to terminate the Merger Agreement in order to accept a superior proposal since our stockholders have voted to approve the adoption of the Merger Agreement.

The number of shares of Aetna common stock that our stockholders will receive in the Merger is based on a fixed exchange ratio. Because the market price of Aetna's common stock will fluctuate, our stockholders cannot be certain of the value of the portion of the merger consideration to be paid in Aetna common stock.

Upon completion of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash without interest, subject to any required withholding taxes. The exchange ratio for determining the number of shares of Aetna common stock that our stockholders will receive in the Merger is fixed and will not be adjusted for changes in the market price of Aetna's common stock, which will likely fluctuate before and after the completion of the Merger. Fluctuations in the value of Aetna's common stock could result from changes in the business, operations or prospects of Aetna prior to or following the closing of the Merger, regulatory considerations, general market and economic conditions and other factors both within and beyond the control of us or Aetna.

While the Merger is pending, we are subject to business uncertainties and contractual restrictions that could materially adversely affect our results of operations, financial position and cash flows or result in a loss of employees, customers, members or suppliers.

The Merger Agreement includes restrictions on the conduct of our business prior to the completion or termination of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent Aetna's prior written consent. We may find that these and other contractual restrictions in the Merger Agreement may delay or prevent us from responding, or limit our ability to respond, effectively to competitive pressures, industry developments and future business opportunities that may arise during such period, even if our management believes they may be advisable. The pendency of the Merger may also divert management's attention and our resources from ongoing business and operations.

Our employees, customers, members and suppliers may experience uncertainties about the effects of the Merger. In connection with the pending Merger, it is possible that some customers, members, suppliers and other parties with whom we have a business relationship may delay or defer certain business decisions or might decide to seek to terminate, change or renegotiate their relationship with us as a result of the Merger. Similarly, current and prospective employees may experience uncertainty about their future roles with us following completion of the Merger, which may materially adversely affect our ability to attract and retain key employees. If any of these effects were to occur, it could materially and adversely impact our results of operations, financial position, cash flows and the price per share for our common stock.

Failure to consummate the Merger could negatively impact our results of operations, financial position, cash flows and the price per share for our common stock.

If the Merger is not consummated, our ongoing businesses may be materially and adversely affected and, we will not have realized any of the potential benefits of having consummated the transaction, and we will be subject to a number of risks, including the following:

- matters relating to the Merger (including integration planning) may require substantial commitments of time and resources by our management, which could otherwise have been devoted to other opportunities that may have been beneficial to us;
- the Merger Agreement includes restrictions on the conduct of our business prior to the completion or termination of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent Aetna's prior written consent. We may find that these and other contractual restrictions in the Merger Agreement may delay or prevent us from responding, or limit our ability to respond, effectively to competitive pressures, industry developments and future business opportunities that may arise during such period, even if our management believes they may be advisable. The pendency of the Merger may also divert management's attention and our resources from ongoing business and operations;
- we may be required to pay a termination fee to Aetna and would have incurred expenses relating to the Merger; and

- we also could be subject to litigation related to our failure to consummate the Merger or to perform our obligations under the Merger Agreement.

If the Merger is not consummated, these risks may materially and adversely affect our results of operations, financial position, cash flows and the price per share for our common stock.

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, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, participation in health insurance exchanges, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee and other assessments under the Health Care Reform Law), and implementation of regulatory requirements may increase our operating expenses.

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

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

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

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

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

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

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 72% of our total premiums and services revenue for the year ended December 31, 2015 generated from our Medicare products, including 14% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

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

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

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

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

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

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

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

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

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

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

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

Our business may be materially adversely impacted by the adoption of a new coding set for diagnoses.

Federal regulations related to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. On October 1, 2015, ICD-10, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States, replaced the prior set of codes. For dates of service on or after October 1, 2015, health plans and providers are required to use ICD-10 codes for such diagnoses and procedures. While we prepared for the transition to ICD-10, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, including providers in our network who are employees, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in increased claim submissions or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. If we do not adequately implement the new ICD-10 coding set, or if providers in our network do not adequately transition to the new ICD-10 coding set, our results of operations, financial position and cash flows may be materially adversely affected.

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 73% of our total premiums and services revenue for the year ended December 31, 2015. These programs involve various risks, as described further below.

- At December 31, 2015, under our contracts with CMS we provided health insurance coverage to approximately 587,400 individual Medicare Advantage members in Florida. These contracts accounted for approximately 14% of our total premiums and services revenue for the year ended December 31, 2015. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2015, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3,074,400 beneficiaries. For the year ended December 31, 2015,

premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 1% of our total premiums and services revenue. On April 1, 2012, we began delivering services under the current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On January 22, 2016, we received notice from the DHA of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2017. The loss of the TRICARE South Region contract, should it occur, may have a material adverse effect on our results of operations, financial position, and cash flows.

- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.
- CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.
- In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits currently being conducted for contract year 2011 in which two of our Medicare Advantage plans are being audited. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We were notified on September 15, 2015, that five of our Medicare Advantage contracts have been selected for audit for contract year 2012.

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

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

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

The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a “risk corridor”). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $22 million at December 31, 2015.

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 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.

- The Budget Control Act of 2011 increased the United States debt ceiling conditioned on deficit reductions to be achieved over the next ten years. The Budget Control Act of 2011 also established a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. The failure of the Joint Select Committee on Deficit Reduction to achieve a targeted deficit reduction by December 23, 2011 triggered an automatic reduction, including aggregate reductions to Medicare payments to providers of up to 2 percent per fiscal year. These reductions took effect on April 1, 2013, and the Bipartisan Budget Act of 2013, enacted on December 26, 2013, extended the reductions for two years. We expect a corresponding substantial reduction in our obligations to providers. Due to the uncertainty around the application of any such reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.
- 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

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with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. 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 participation in the new federal and state health insurance exchanges, which entail uncertainties associated with mix, volume of business and the operation of premium stabilization programs, which are subject to federal administrative action, could adversely affect our results of operations, financial position, and cash flows.

The Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. During 2015, we received our interim settlement associated with our risk corridor receivables for the 2014 coverage year. The interim settlement, representing only 12.6% of risk corridor receivables for the 2014 coverage year, was funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 risk corridor program. HHS provided guidance under the three year risk corridor program that future collections will first be applied to any shortfalls from previous coverage years before application to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

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 the U.S. Department of Health and Human Services 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 the U.S. Department of Health and Human Services 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 Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2015:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	123	1	96	231
Texas	—	15	2	24	41
Kentucky	2	1	11	12	26
Virginia	—	8	—	8	16
California	—	2	—	13	15
Arizona	—	8	—	7	15
Louisiana	—	4	—	10	14
Ohio	—	1	—	13	14
Illinois	—	5	—	8	13
New York	—	—	—	13	13
Georgia	—	7	—	3	10
Tennessee	—	—	—	10	10
North Carolina	—	—	—	10	10
Nevada	—	5	—	5	10
South Carolina	—	—	4	6	10
Indiana	—	2	—	7	9
Puerto Rico	—	—	—	9	9
New Jersey	—	—	—	8	8
Colorado	—	3	—	4	7
Pennsylvania	—	—	—	6	6
Wisconsin	—	—	1	5	6
Others	—	3	—	47	50
Total	13	187	19	324	543

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, urgent care facilities, and worksite medical facilities. Of the medical centers included in the table above, approximately 64 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, 2015 and 2014:

	High	Low
Year Ended December 31, 2015		
First quarter	$182.79	$139.09
Second quarter	$214.92	$163.07
Third quarter	$193.14	$174.16
Fourth quarter	$186.67	$164.25
Year Ended December 31, 2014		
First quarter	$118.78	$95.59
Second quarter	$128.95	$104.74
Third quarter	$135.51	$115.97
Fourth quarter	$149.07	$124.17

Holders of our Capital Stock

As of January 31, 2016, there were approximately 2,900 holders of record of our common stock and approximately 41,200 beneficial holders of our common stock.

Dividends

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

Record Date	Payment Date	Amount per Share	Total Amount (in millions)
2014 payments			
12/31/2013	1/31/2014	$0.27	$42
3/31/2014	4/25/2014	$0.27	$42
6/30/2014	7/25/2014	$0.28	$43
9/30/2014	10/31/2014	$0.28	$43
2015 payments			
12/31/2014	1/30/2015	$0.28	$42
3/31/2015	4/24/2015	$0.28	$42
6/30/2015	7/31/2015	$0.29	$43
9/30/2105	10/30/2015	$0.29	$43

The Merger discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data does not impact our ability and intent to continue quarterly dividend payments prior to the closing of the Merger consistent with our historical dividend payments. Under the terms of the Merger Agreement, we have agreed with Aetna that our quarterly dividend will not exceed $0.29 per share prior to the closing of the Merger.

Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. In addition, under the terms of the Merger Agreement, we have agreed with Aetna to coordinate the declaration and payment of dividends so that our stockholders do not fail to receive a quarterly dividend around the time of the closing of the Merger.

On October 29, 2015, the Board declared a cash dividend of $0.29 per share that was paid on January 29, 2016 to stockholders of record on December 30, 2015, for an aggregate amount of $43 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, 2015. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2010, and that dividends were reinvested when paid.

	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015
HUM	$100	$162	$128	$195	$274	$343
S&P 500	$100	$102	$118	$157	$178	$181
Peer Group	$100	$110	$129	$177	$226	$239

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, 2015 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)
October 2015	—	$—	—	$—
November 2015	—	—	—	—
December 2015	—	—	—	—
Total	—	$—	—	

(1) In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion with a current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Pursuant to the Merger Agreement, after July 2, 2015, we are prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we have suspended our share repurchase program. Our remaining repurchase authorization was $1.04 billion as of July 3, 2015.

(2) Excludes 0.3 million shares repurchased in connection with employee stock plans.

The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna’s prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

ITEM 6. SELECTED FINANCIAL DATA

	2015 (a)	2014 (b)	2013 (c)	2012 (d)	2011
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$52,409	$45,959	$38,829	$37,009	$35,106
Services	1,406	2,164	2,109	1,726	1,360
Investment income	474	377	375	391	366
Total revenues	54,289	48,500	41,313	39,126	36,832
Operating expenses:					
Benefits	44,269	38,166	32,564	30,985	28,823
Operating costs	7,318	7,639	6,355	5,830	5,395
Depreciation and amortization	355	333	333	295	270
Total operating expenses	51,942	46,138	39,252	37,110	34,488
Income from operations	2,347	2,362	2,061	2,016	2,344
Interest expense	186	192	140	105	109
Gain on sale of business	270	—	—	—	—
Income before income taxes	2,431	2,170	1,921	1,911	2,235
Provision for income taxes	1,155	1,023	690	689	816
Net income	$1,276	$1,147	$1,231	$1,222	$1,419
Basic earnings per common share	$8.54	$7.44	$7.81	$7.56	$8.58
Diluted earnings per common share	$8.44	$7.36	$7.73	$7.47	$8.46
Dividends declared per common share	$1.15	$1.11	$1.07	$1.03	$0.75
Financial Position:					
Cash and investments	$11,681	$11,482	$10,938	$11,153	$10,830
Total assets	24,705	23,527	20,735	19,979	17,708
Benefits payable	4,976	4,475	3,893	3,779	3,754
Debt	3,821	3,825	2,600	2,611	1,659
Stockholders’ equity	10,346	9,646	9,316	8,847	8,063
Cash flows from operations	$868	$1,618	$1,716	$1,923	$2,079
Key Financial Indicators:					
Benefit ratio	84.5 %	83.0 %	83.9 %	83.7 %	82.1 %
Operating cost ratio	13.6 %	15.9 %	15.5 %	15.1 %	14.8 %
Membership by Segment:					
Retail segment:					
Medical membership	9,226,800	8,376,500	6,459,300	5,956,700	5,117,400
Specialty membership	1,153,100	1,165,800	1,042,500	948,700	782,500
Group segment:					
Medical membership	4,963,400	5,430,200	5,501,600	5,573,400	5,500,600
Specialty membership	6,068,700	6,502,700	6,780,800	7,136,200	6,532,600
Other Businesses:					
Medical membership	32,600	35,000	23,400	558,700	566,600
Consolidated:					
Total medical membership	14,222,800	13,841,700	11,984,300	12,088,800	11,184,600
Total specialty membership	7,221,800	7,668,500	7,823,300	8,084,900	7,315,100

(a) 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.

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

(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.

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

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

Executive Overview

General

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

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

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we will merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. A copy of the Merger Agreement was filed as Exhibit 2.1 to our Current Report on Form 8-K filed with the U.S. Securities and Exchange Commission on July 7, 2015. Under the terms of the Merger Agreement, at the closing of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash. The total transaction was estimated at approximately $37 billion including the assumption of Humana debt, based on the closing price of Aetna common shares on July 2, 2015. The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

On October 19, 2015, our stockholders approved the adoption of the Merger Agreement at a special stockholder meeting. Of the 129,240,721 shares voting at the meeting, more than 99% voted in favor of the adoption of the Merger Agreement, which represented approximately 87% of our total outstanding shares of common stock as of the September 16, 2015 record date. Also on October 19, 2015, the holders of Aetna outstanding shares approved the issuance of Aetna common stock in the Merger at a special meeting of Aetna shareholders.

The Merger is 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, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect

to our Medicare Advantage, or MA, business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and our subsidiaries, taken as a whole. The Merger is currently expected to close in the second half of 2016.

Business Segments

On January 1, 2015, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes and renamed our Employer Group segment to the Group segment. Our three reportable segments remain Retail, Group, and Healthcare Services. The more significant realignments included reclassifying Medicare benefits offered to groups to the Retail segment from the Group segment, bringing all of our Medicare offerings, which are now managed collectively, together in one segment, recognizing that in some instances we market directly to individuals that are part of a group Medicare account. In addition, we realigned our military services business, primarily consisting of our TRICARE South Region contract previously included in the Other Businesses category, to our Group segment as we consider this contract with the government to be a group account. Prior period segment financial information has been recast to conform to the 2015 presentation. This is further described in Note 2 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

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

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

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

Seasonality

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

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

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

2015 Highlights

Consolidated

- Our 2015 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, 2015, approximately 1,633,100 members, or 59.3%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,301,000 members, or 53.6%, at December 31, 2014.
- On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million, or $1.57 per diluted common share in 2015.

- During 2015, we recorded transaction costs in connection with the Merger of approximately $23.1 million, or $0.14 per diluted common share. Certain costs associated with the transaction are not deductible for tax purposes.
- Excluding the impact of the sale of Concentra and transaction costs associated with the Merger, our pretax results for 2015 as compared to 2014 reflect year-over-year improvement in the Group and Healthcare Services segment pretax results and higher investment income, partially offset by a year-over-year decline in Retail segment pretax results as discussed in the detailed segment results discussion that follows.
- Year-over-year comparisons of the operating cost ratio are impacted by an increase in 2015 of the non-deductible health insurance industry fee mandated by the Health Care Reform Law. Likewise, year-over-year comparisons of the benefit ratio reflect the increase in this fee in the pricing of our products for 2015 which reduces our benefit ratio.
- Investment income increased $97 million in 2015, primarily due to higher realized capital gains in 2015 as a result of the repositioning of our portfolio given recent market volatility and anticipated changes to interest rates.
- Year-over-year comparisons of diluted earnings per common share are favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.
- Operating cash flow provided by operations was $868 million for the year ended December 31, 2015 as compared to operating cash flow of $1.6 billion for the year ended December 31, 2014. The decrease in our operating cash flows primarily reflects the effect of significant growth in individual commercial medical and group Medicare Advantage membership in the prior year and changes in the timing of other working capital items related to the growth in our pharmacy business and growth in net receivables under the commercial risk adjustment, reinsurance, and risk corridor programs under the Health Care Reform Law, commonly referred to as the 3Rs. Prior year cash flows were favorably impacted from the typical pattern of claim payments that lagged premium receipts related to new membership. Individual commercial medical added 548,000 new members in 2014 compared to a decline of 90,400 members in 2015. Likewise, group Medicare Advantage added 60,600 new members in 2014 compared to a decline of 5,600 members in 2015.
- In 2015, we paid the federal government $867 million for the annual non-deductible health insurance industry fee compared to our payment of $562 million in 2014. This fee is not deductible for tax purposes, which significantly increased our effective income tax rate beginning in 2014. The health insurance industry fee is further described below under the section titled "Health Care Reform." The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This will significantly reduce our effective tax rate in 2017.
- During 2015, we repurchased 1.85 million shares in open market transactions for $329 million and paid dividends to stockholders of $172 million. Pursuant to the Merger Agreement, after July 2, 2015, we are prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we have suspended our share repurchase program. Our remaining repurchase authorization was $1.04 billion as of July 3, 2015. The Merger does not impact our ability and intent to continue quarterly dividend payments prior to the closing of the Merger consistent with our historical dividend payments. Under the terms of the Merger Agreement, we have agreed with Aetna that our quarterly dividend will not exceed $0.29 per share prior to the closing of the Merger.

Retail Segment

- On April 6, 2015, CMS announced final 2016 Medicare benchmark payment rates and related technical factors impacting the bid benchmark premiums, which we refer to as the Final Rate Notice. We believe the Final Rate Notice, together with the impact of payment cuts associated with the Health Care Reform Law, quality bonuses,

risk coding modifications, and other funding formula changes, indicated 2016 Medicare Advantage funding increases for us of approximately 1.0% on average. Although the overall rate adjustment is positive, geographic-specific impacts may vary significantly from this average, particularly in Florida. We believe we have effectively designed Medicare Advantage products based upon the applicable level of rate changes while continuing to remain competitive compared to both the combination of original Medicare with a supplement policy and Medicare Advantage products offered by our competitors. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

- In 2015, our Retail segment pretax income decreased by $409 million, or 30.5%, from 2014 primarily due to higher Medicare Advantage and individual commercial medical benefit ratios year-over-year, including the impact of benefits expense associated with a premium deficiency reserve for certain of our individual commercial products for the 2016 coverage year as described further below and in the results of operations discussion that follows. The higher benefit ratios were partially offset by declines in the Retail segment operating cost ratios, Medicare membership growth, and higher investment income year-over-year.

Individual Medicare Advantage operating results for 2015 included significant membership growth but were negatively impacted by certain developments related to our product pricing assumptions for 2015. These developments primarily related to lower-than-expected 2015 financial claim recovery levels (included in medical claims reserve development) and lower-than-anticipated reductions in inpatient admissions. Claims data from the fourth quarter of 2015 and early 2016 indicate that inpatient admissions continue to develop favorably versus expectations and claim recoveries have stabilized. We are closely monitoring these favorable trends.

- Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. The benefit ratios associated with many of our individual commercial medical products, in particular Health Care Reform Law compliant offerings, significantly exceeded prior expectations for fiscal year 2015, driven primarily by the on-going impact of the transitional policies, special enrollment period exemptions associated with the program, and government-mandated product designs that attracted higher-utilizing members . Additionally, on June 30, 2015, CMS issued data with respect to the reinsurance and risk adjustment premium stabilization programs for the 2014 plan year which indicated a healthier risk profile comparison for our membership relative to state averages than had been previously anticipated. This resulted in adjustments to certain of the 3Rs during 2015.

We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016.These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million, or $0.74 per diluted common share. The premium deficiency reserve includes the estimated benefit of approximately $340 million associated with risk corridor provisions expected for the 2016 coverage year.

In light of the premium deficiency reserve recognized in the fourth quarter of 2015 for the 2016 coverage year, results for this business for 2016 are expected to primarily include results associated with the wind-down of plans that are not compliant with the Health Care Reform Law, including the related release of policy reserves, as well as indirect administrative costs associated with plans that are compliant with the Health Care Reform Law. We are continuing to evaluate our participation in the individual commercial medical line of business for 2017.

- Individual Medicare Advantage membership of 2,753,400 at December 31, 2015 increased 325,500 members, or 13.4%, from 2,427,900 at December 31, 2014 reflecting net membership additions, particularly for our Health Maintenance Organization, or HMO, offerings, for the 2015 plan year. January 2016 individual Medicare Advantage membership approximated 2,811,000, increasing approximately 57,600 members, or 2%, from December 31, 2015 reflecting net membership additions during the recently completed 2016 annual election period for Medicare beneficiaries. For full year 2016, we anticipate net membership growth in our individual Medicare Advantage offerings of 100,000 to 120,000.
- Group Medicare Advantage membership of 484,100 at December 31, 2015 decreased 5,600 members, or 1.1%, from 489,700 at December 31, 2014. For full year 2016, we expect a net membership decline in our Group Medicare Advantage offerings of 120,000 to 125,000 members primarily due to the loss of a large account that converted to a private exchange offering. Approximately 50% of members from that account selected an individual Humana offering for 2016, with the majority enrolling in a Medicare supplement plan.
- Medicare stand-alone PDP membership of 4,557,900 at December 31, 2015 increased 563,900 members, or 14.1%, from 3,994,000 at December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2015 plan year. January 2016 Medicare stand-alone PDP membership (excluding transitional growth from the LI-NET prescription drug plan program) increased approximately 240,000 members, or 5%, from December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, during the recently completed 2016 annual election period for Medicare beneficiaries. For full year 2016, we anticipate net membership growth in our Medicare stand-alone PDP offerings of 300,000 to 330,000.
- Our state-based Medicaid membership of 373,700 at December 31, 2015 increased 56,900 members, or 18.0%, from 316,800 at December 31, 2014 primarily driven by the addition of members under our Florida Medicaid contract.
- Individual commercial medical membership of 1,057,700 at December 31, 2015 decreased 90,400 members, or 7.9%, from 1,148,100 at December 31, 2014 primarily reflecting the loss of approximately 150,000 members due to termination by CMS for lack of proper eligibility documentation from the member as well as the loss of members who had subscribed to plans that were not compliant with the Health Care Reform Law. These declines were partially offset by an increase in membership in plans that are compliant with the Health Care Reform Law, primarily off-exchange. Individual commercial medical membership in plans compliant with the Health Care Reform Law experienced growth in 2015, but at a lesser rate than in 2014. At December 31, 2015, individual commercial medical membership in plans compliant with the Health Care Reform Law, both on-exchange and off-exchange, was 757,900 members, an increase of 71,600 members or 10.4% from December 31, 2014.

We expect a net decline in individual commercial medical membership (excluding Medicare Supplement) for full year 2016 of 200,000 to 300,000, primarily reflecting increases in premiums as well as benefit redesigns that took effect on January 1, 2016. This membership expectation takes into account plans compliant with the Health Care Reform Law, both on and off exchange, and legacy plans that are not compliant with the Health Care Reform Law. Membership estimates for 2016 include the expectation of coverage termination by 50% to 60% of the approximately 100,000 members impacted by plan discontinuances.

Group Segment

- Group segment pretax income grew $107 million, or 70.9%, for the year ended December 31, 2015 primarily due to improvement in the operating cost ratio partially offset by an increase in the benefit ratio as discussed in the results of operations discussion that follows.
- Membership in HumanaVitality®, our wellness and loyalty rewards program, rose 2.0% to 3,932,300 at December 31, 2015 from 3,856,800 at December 31, 2014.

Healthcare Services Segment

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

As discussed in the detailed Healthcare Services segment results of operations discussion that follows, our Healthcare Services segment pretax income increased $243 million, or 32.9%, for the year ended December 31, 2015. This increase was primarily due to higher earnings from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership. High levels of Medicare membership growth as well as increased engagement of members in clinical programs have resulted in higher usage of services across this segment. In addition, improved operating efficiency in the pharmacy business primarily was driven by lower cost of goods associated with increased purchasing scale and lower cost-to-fill primarily due to improvements in technology.

- Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We have expanded our identification of and outreach to members in need of clinical intervention. At December 31, 2015, we enrolled approximately 590,300 Medicare Advantage members with complex chronic conditions in the Humana Chronic Care Program, a 40.3% increase compared with approximately 420,700 members at December 31, 2014, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry was $8 billion in 2014 and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter, and is not deductible for income tax purposes, which significantly increased our effective income tax rate. Our effective tax rate for 2015 was approximately 47.5%, including the favorable impact of the sale of Concentra on June 1, 2015. Our effective tax rate for 2016 is expected to be approximately 49% to 51%, excluding the impact of transaction costs associated with the Merger. In 2015, we paid the federal government $867 million for the annual health insurance industry fee, a 54.3% increase from $562 million in 2014, primarily reflecting an increase in the total industry fee. We expect our portion of the annual health insurance industry fee for 2016 to be higher than in 2015 given growth in our market share. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This will significantly reduce our effective tax rate in 2017. The health insurance industry fee levied on the insurance industry was previously expected to be $14 billion in 2017.

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 2015 10-K.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk

corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange. In addition, states may impose restrictions on our ability to increase rates. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows and could impact our decision to participate or continue in the program in certain states.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows (including the delayed receipt of amounts due under the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law). During 2015, we received our interim settlement associated with our risk corridor receivables for the 2014 coverage year. The interim settlement, representing only 12.6% of risk corridor receivables for the 2014 coverage year, was funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 risk corridor program. The risk corridor program is a three year program and HHS guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2015 10-K.

Comparison of Results of Operations for 2015 and 2014

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

Consolidated

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

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

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

Summary

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

of $1.57 per diluted common share in 2015. Excluding the impact of the sale of Concentra, the decrease primarily was due to a decline in Retail segment pretax results, including expense of $0.74 per diluted common share for a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and an increase in the effective tax rate as discussed below. These items were partially offset by year-over-year improvement in the Group and Healthcare Services segment pretax results and higher investment income. In addition, 2015 includes expenses of $0.14 per diluted common share for transaction costs associated with the Merger, certain of which are not deductible for tax purposes. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014. Year-over-year comparisons of diluted earnings per common share are also favorably impacted by a lower number of shares used to compute diluted earnings per common share in 2015 reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $6.5 billion, or 14.0%, from 2014 to $52.4 billion for 2015 primarily reflecting higher premiums in both the Retail and Group segments. These higher premiums were primarily driven by average membership growth in the Retail segment and an increase in fully-insured group commercial medical per member premiums in the Group segment. 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 $758 million, or 35.0%, from 2014 to $1.4 billion for 2015 primarily due to the completion of the sale of Concentra on June 1, 2015 as well as the loss of certain large group ASO accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

Investment Income

Investment income totaled $474 million for 2015, an increase of $97 million, or 25.7%, from 2014, primarily due to higher realized capital gains in 2015 as a result of the repositioning of our portfolio given recent market volatility and anticipated changes to interest rates, with higher average invested balances being substantially offset by lower interest rates.

Benefits Expense

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

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

Operating Costs

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 $321 million, or 4.2%, from 2014 to $7.3 billion in 2015 primarily due to cost management initiatives across all lines of business as well as the completion of the sale of Concentra on June 1, 2015, partially offset by increases in costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee.

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

Depreciation and Amortization

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

Interest Expense

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

Income Taxes

Our effective tax rate during 2015 was 47.5% compared to the effective tax rate of 47.2% in 2014. The increase in the effective tax rate primarily was due to an increase in the non-deductible health insurance industry fee from 2014, substantially offset by the favorable tax effect of the gain on the sale of Concentra. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate. Our effective tax rate for 2016 is expected to be approximately 49% to 51%, excluding the impact of any non-deductible transaction costs associated with the Merger.

Retail Segment

	2015	2014	Change Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,753,400	2,427,900	325,500	13.4 %
Group Medicare Advantage	484,100	489,700	(5,600)	(1.1)%
Medicare stand-alone PDP	4,557,900	3,994,000	563,900	14.1 %
Total Retail Medicare	7,795,400	6,911,600	883,800	12.8 %
Individual commercial (a)	1,057,700	1,148,100	(90,400)	(7.9)%
State-based Medicaid	373,700	316,800	56,900	18.0 %
Total Retail medical members	9,226,800	8,376,500	850,300	10.2 %
Individual specialty membership (b)	1,153,100	1,165,800	(12,700)	(1.1)%

(a) Individual commercial medical membership includes Medicare Supplement members.
Specialty products include dental, vision, and other supplemental health and financial protection products.

(b) Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2015 (in millions)	2014	Change Dollars	Percentage
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$29,526	$25,782	$3,744	14.5 %
Group Medicare Advantage	5,588	5,490	98	1.8 %
Medicare stand-alone PDP	3,846	3,404	442	13.0 %
Total Retail Medicare	38,960	34,676	4,284	12.4 %
Individual commercial	4,243	3,265	978	30.0 %
State-based Medicaid	2,341	1,255	1,086	86.5 %
Individual specialty	261	256	5	2.0 %
Total premiums	45,805	39,452	6,353	16.1 %
Services	9	39	(30)	(76.9)%
Total premiums and services revenue	$45,814	$39,491	$6,323	16.0 %
Income before income taxes	$930	$1,339	$(409)	(30.5)%
Benefit ratio	86.7 %	84.9 %		1.8 %
Operating cost ratio	11.2 %	11.6 %		(0.4)%

Pretax Results

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

Enrollment

- Individual Medicare Advantage membership increased 325,500 members, or 13.4%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, particularly for our HMO offerings, for the 2015 plan year.
- Group Medicare Advantage membership decreased 5,600 members, or 1.1%, from December 31, 2014 to December 31, 2015.
- Medicare stand-alone PDP membership increased 563,900 members, or 14.1%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2015 plan year.
- Individual commercial medical membership decreased 90,400 members, or 7.9%, from December 31, 2014 to December 31, 2015 primarily reflecting the loss of approximately 150,000 members due to termination by CMS for lack of proper eligibility documentation from the member as well as the loss of members who had subscribed to plans that were not compliant with the Health Care Reform Law. These declines were partially offset by an increase in membership in plans that are compliant with the Health Care Reform Law, primarily off-exchange.
- State-based Medicaid membership increased 56,900 members, or 18.0%, from December 31, 2014 to December 31, 2015 primarily driven by the addition of members under our Florida Medicaid contract.
- Individual specialty membership decreased 12,700 members, or 1.1%, from December 31, 2014 to December 31, 2015 primarily driven by a membership decline in supplemental health and financial protection product and vision offerings.

Premiums revenue

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

Benefits expense

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

We experienced higher than expected medical costs as compared to the assumptions used in our pricing for 2015 primarily due to lower-than-expected 2015 Medicare Advantage financial claim recovery levels and lower-than-anticipated reductions in inpatient admissions. In addition, medical claims associated with certain individual commercial medical products, in particular products compliant with the Health Care Reform Law, exceeded the assumptions used when we set pricing for 2015. We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and

administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the Retail segment benefit ratio by approximately 40 basis points in 2015.

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

Operating costs

- The Retail segment operating cost ratio of 11.2% for 2015 decreased 40 basis points from 2014 primarily reflecting administrative cost efficiencies associated with medical membership growth in the segment and other discretionary cost reductions, partially offset by the increase in the non-deductible health insurance industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2015 as compared to 120 basis points in 2014.

Group Segment

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

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

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

Pretax Results

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

Enrollment

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

Premiums revenue

- Group segment premiums increased $113 million, or 1.8%, from 2014 to 2015 primarily due to an increase in fully-insured commercial medical per member premiums partially offset by a net decline in fully-insured commercial medical membership.

Services revenue

- Group segment services revenue decreased $65 million, or 8.5%, from 2014 to 2015 primarily due to a decline in group ASO commercial medical membership.

Benefits expense

- The Group segment benefit ratio increased 70 basis points from 79.5% in 2014 to 80.2% in 2015 primarily reflecting the impact of higher specialty drug costs, net of rebates, as well as higher outpatient costs and lower prior-period medical claims reserve development, partially offset by an increase in the non-deductible health insurance industry fee included in the pricing of our products.
- The Group segment’s benefits expense included the beneficial effect of $7 million in favorable prior-year medical claims reserve development versus $29 million in 2014. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 10 basis points in 2015 versus approximately 40 basis points in 2014. The year-over-year decline in favorable prior-period medical

claims reserve development primarily was due to a relatively small number of higher severity claims in the 2015 period associated with prior periods.

Operating costs

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

Healthcare Services Segment

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

Pretax results

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

Script Volume

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

Services revenue

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

Intersegment revenues

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

Operating costs

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

Comparison of Results of Operations for 2014 and 2013

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2014 and 2013:

Consolidated

	2014	2013	Change Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$39,452	$31,922	$7,530	23.6 %
Group	6,456	6,237	219	3.5 %
Other Businesses	51	670	(619)	(92.4)%
Total premiums	45,959	38,829	7,130	18.4 %
Services:				
Retail	39	18	21	116.7 %
Group	763	735	28	3.8 %
Healthcare Services	1,353	1,350	3	0.2 %
Other Businesses	9	6	3	50.0 %
Total services	2,164	2,109	55	2.6 %
Investment income	377	375	2	0.5 %
Total revenues	48,500	41,313	7,187	17.4 %
Operating expenses:				
Benefits	38,166	32,564	5,602	17.2 %
Operating costs	7,639	6,355	1,284	20.2 %
Depreciation and amortization	333	333	—	— %
Total operating expenses	46,138	39,252	6,886	17.5 %
Income from operations	2,362	2,061	301	14.6 %
Interest expense	192	140	52	37.1 %
Income before income taxes	2,170	1,921	249	13.0 %
Provision for income taxes	1,023	690	333	48.3 %
Net income	$1,147	$1,231	$(84)	(6.8)%
Diluted earnings per common share	$7.36	$7.73	$(0.37)	(4.8)%
Benefit ratio (a)	83.0 %	83.9 %		(0.9)%
Operating cost ratio (b)	15.9 %	15.5 %		0.4 %
Effective tax rate	47.2 %	35.9 %		11.3 %

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

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

Summary

Net income was $1.1 billion, or $7.36 per diluted common share, in 2014 compared to $1.2 billion, or $7.73 per diluted common share, in 2013. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014 and net income for 2013 includes benefits expense of $0.99 per diluted common share for reserve strengthening associated with our closed-

block of long-term care insurance policies included with Other Businesses as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data as well as the benefit of a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the DoD. Excluding these items, the increase in net income primarily resulted from higher pretax income in our Healthcare Services segment substantially offset by lower pretax income in our Retail and Group segments. In addition, 2014 was favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $7.1 billion, or 18.4%, from 2013 to $46.0 billion for 2014 primarily due to increases in both Retail and Group segment premiums mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. In addition, year-over-year comparisons to 2013 were negatively impacted by sequestration which became effective April 1, 2013. Premiums revenue for our Other Businesses declined primarily due to the loss of our Puerto Rico Medicaid contracts effective September 30, 2013.

Services Revenue

Consolidated services revenue increased $55 million, or 2.6%, from 2013 to $2.2 billion for 2014 primarily due to an increase in services revenue in our Retail segment due to the acquisition of American Eldercare in September 2013.

Investment Income

Investment income totaled $377 million for 2014, an increase of $2 million from 2013, as higher average invested balances were partially offset by lower interest rates.

Benefits Expense

Consolidated benefits expense was $38.2 billion for 2014, an increase of $5.6 billion, or 17.2%, from 2013 primarily due to increases in both the Retail and Group segments mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. We experienced favorable medical claims reserve development related to prior fiscal years of $518 million in 2014 and $474 million in 2013. These increases in favorable medical claims reserve development primarily resulted from increased membership and better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements. The consolidated benefit ratio for 2014 was 83.0%, a decrease of 90 basis points from 2013 primarily due to reserve strengthening in 2013 associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed above, as well as the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 which more than offset higher ratios year-over-year in the Retail and Group segments.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent. Consolidated operating costs increased $1,284 million, or 20.2%, in 2014 compared to 2013 primarily due to costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee, and investments in health care exchanges and state-based contracts, partially offset by operating cost efficiencies. The consolidated operating cost ratio for 2014 was 15.9%, increasing 40 basis points from 2013 primarily due to increases in the operating cost ratios in our Retail and Group segments due to the same factors impacting consolidated operating costs as described above.

Depreciation and Amortization

Depreciation and amortization for 2014 totaled $333 million, unchanged from 2013.

Interest Expense

Interest expense was $192 million for 2014 compared to $140 million for 2013, an increase of $52 million, or 37.1%. In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, We recognized a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of these notes.

Income Taxes

Our effective tax rate during 2014 was 47.2% compared to the effective tax rate of 35.9% in 2013. The non-deductible nature of the health insurance industry fee levied on the insurance industry beginning in 2014 as mandated by the Health Care Reform Law increased our effective tax rate by approximately 9.4 percentage points for 2014.

Retail Segment

	2014	2013	Change Members	Percentage	
Membership:					
Medical membership:					
Individual Medicare Advantage	2,427,900	2,068,700	359,200	17.4	%
Group Medicare Advantage	489,700	429,100	60,600	14.1	%
Medicare stand-alone PDP	3,994,000	3,275,900	718,100	21.9	%
Total Retail Medicare	6,911,600	5,773,700	1,137,900	19.7	%
Individual commercial (a)	1,148,100	600,100	548,000	91.3	%
State-based Medicaid	316,800	85,500	231,300	270.5	%
Total Retail medical members	8,376,500	6,459,300	1,917,200	29.7	%
Individual specialty membership (b)	1,165,800	1,042,500	123,300	11.8	%

(a) Individual commercial medical membership includes Medicare Supplement members.

Specialty products include dental, vision, and other supplemental health and financial protection products.

(b) Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2014	2013	Change Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$25,782	$22,481	$3,301	14.7 %
Group Medicare Advantage	5,490	4,710	780	16.6 %
Medicare stand-alone PDP	3,404	3,033	371	12.2 %
Total Retail Medicare	34,676	30,224	4,452	14.7 %
Individual commercial	3,265	1,160	2,105	181.5 %
State-based Medicaid	1,255	328	927	282.6 %
Individual specialty	256	210	46	21.9 %
Total premiums	39,452	31,922	7,530	23.6 %
Services	39	18	21	116.7 %
Total premiums and services revenue	$39,491	$31,940	$7,551	23.6 %
Income before income taxes	$1,339	$1,490	$(151)	(10.1)%
Benefit ratio	84.9 %	85.1 %		(0.2)%
Operating cost ratio	11.6 %	10.1 %		1.5 %

Pretax Results

- Retail segment pretax income was $1.3 billion in 2014, a decrease of $151 million, or 10.1%, compared to 2013 primarily driven by investment spending for health care exchanges and state-based contracts and higher specialty prescription drug costs associated with a new treatment for Hepatitis C, partially offset by Medicare Advantage and individual commercial medical membership growth as well as increased membership in our clinical programs.

Enrollment

- Individual Medicare Advantage membership increased 359,200 members, or 17.4%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, particularly for our HMO offerings, for the 2014 plan year.
- Fully-insured group Medicare Advantage membership increased 60,600 members, or 14.1%, from December 31, 2013 to December 31, 2014 primarily due to the addition of a new large group account.
- Medicare stand-alone PDP membership increased 718,100 members, or 21.9%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2014 plan year.
- Individual commercial medical membership increased 548,000 members, or 91.3%, from December 31, 2013 to December 31, 2014 primarily reflecting new sales, both on-exchange and off-exchange, of plans compliant with the Health Care Reform Law.
- State-based Medicaid membership increased 231,300 members, or 270.5%, from December 31, 2013 to December 31, 2014 primarily driven by the addition of members under our Florida Medicaid and Florida Long-Term Support Services contracts as well as 18,300 dual eligible members from state-based contracts in Virginia and Illinois.
- Individual specialty membership increased 123,300 members, or 11.8%, from December 31, 2013 to December 31, 2014 primarily driven by increased membership in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $7.5 billion, or 23.6%, from 2013 to 2014 primarily due to membership growth across all lines of business, particularly for our Medicare Advantage, individual commercial medical, primarily on the health care exchanges, and state-based Medicaid businesses. Individual Medicare Advantage average membership increased 16.6% in 2014. Individual Medicare Advantage per member premiums decreased approximately 1.7% in 2014 compared to 2013, primarily due to Medicare rate reductions and the impact of sequestration which became effective on April 1, 2013.

Benefits expense

- The Retail segment benefit ratio of 84.9% for 2014 decreased 20 basis points from 2013 primarily due to increased membership in our clinical programs and the inclusion of the health insurance industry fee in the pricing of our products, partially offset by higher specialty prescription drug costs associated with a new treatment for Hepatitis C, higher planned clinical investment spending, and higher benefit ratios associated with members from state-based contracts.
- The Retail segment's benefits expense for 2014 included the beneficial effect of $488 million in favorable prior-year medical claims reserve development versus $428 million in 2013. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 120 basis points in 2014 versus approximately 130 basis points in 2013.

Operating costs

- The Retail segment operating cost ratio of 11.6% for 2014 increased 150 basis points from 2013 primarily due to the non-deductible health insurance industry fee mandated by the Health Care Reform Law and investment spending for health care exchanges and state-based contracts, partially offset by scale efficiencies from Medicare and individual commercial medical membership growth.

Group Segment

	2014	2013	Change Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,235,500	1,237,000	(1,500)	(0.1)%
ASO	1,104,300	1,162,800	(58,500)	(5.0)%
Military services	3,090,400	3,101,800	(11,400)	(0.4)%
Total group medical members	5,430,200	5,501,600	(71,400)	(1.3)%
Group specialty membership (a)	6,502,700	6,780,800	(278,100)	(4.1)%

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

	2014	2013	Change Dollars	Percentage
	(in millions)			
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$5,339	$5,117	$222	4.3 %
Group specialty	1,098	1,095	3	0.3 %
Military services	19	25	(6)	(24.0)%
Total premiums	6,456	6,237	219	3.5 %
Services	763	735	28	3.8 %
Total premiums and services revenue	$7,219	$6,972	$247	3.5 %
Income before income taxes	$151	$240	$(89)	(37.1)%
Benefit ratio	79.5 %	77.7 %		1.8 %
Operating cost ratio	26.5 %	26.5 %		— %

Pretax Results

- Group segment pretax income decreased $89 million, or 37.1%, to $151 million in 2014 primarily reflecting higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes which allowed individuals to remain in plans not compliant with the Health Care Reform Law.

Enrollment

- Fully-insured commercial group medical membership decreased 1,500 members, or 0.1% from December 31, 2013 as an increase in small group business membership was generally offset by lower membership in large group accounts. Approximately 65% of our fully-insured commercial group medical membership was in small group accounts at December 31, 2014 compared to 61% at December 31, 2013.
- Group ASO commercial medical membership decreased 58,500 members, or 5.0%, from December 31, 2013 to December 31, 2014 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts.
- Group specialty membership decreased 278,100 members, or 4.1%, from December 31, 2013 to December 31, 2014 primarily due to declines in dental and vision membership related to our planned discontinuance of certain unprofitable product distribution partnerships.

Premiums revenue

- Group segment premiums increased $219.0 million, or 3.5%, from 2013 to 2014 primarily due to higher fully-insured commercial group medical premiums per member that more than offset a slight decline in total membership for this segment.

Benefits expense

- The Group segment benefit ratio increased 180 basis points from 77.7% in 2013 to 79.5% in 2014 primarily due to higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes, partially offset by the inclusion of the health insurance industry fee and other fees mandated by the Health Care Reform Law in our pricing.
- The Group segment’s benefits expense included the beneficial effect of $29 million in favorable prior-year medical claims reserve development versus $42 million in 2013. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 40 basis points in 2014 versus approximately 70 basis points in 2013.

Operating costs

- The Group segment operating cost ratio of 26.5% was unchanged from 2013, reflecting the impact of the non-deductible health insurance industry fee and other fees mandated by the Health Care Reform Law as well as a higher percentage of small group commercial business which carries a higher operating cost ratio than large group business, offset by operating cost efficiencies.

Healthcare Services Segment

	2014	2013	Change Dollars	Percentage
	(in millions)			
Revenues:				
Services:				
Provider services	$1,147	$1,195	$(48)	(4.0)%
Home based services	107	94	13	13.8 %
Pharmacy solutions	99	59	40	67.8 %
Clinical programs	—	2	(2)	(100.0)%
Total services revenues	1,353	1,350	3	0.2 %
Intersegment revenues:				
Pharmacy solutions	16,905	13,079	3,826	29.3 %
Provider services	1,149	1,102	47	4.3 %
Home based services	585	326	259	79.4 %
Clinical programs	208	186	22	11.8 %
Total intersegment revenues	18,847	14,693	4,154	28.3 %
Total services and intersegment revenues	$20,200	$16,043	$4,157	25.9 %
Income before income taxes	$738	$520	$218	41.9 %
Operating cost ratio	95.6 %	95.8 %		(0.2)%

Pretax results

- Healthcare Services segment pretax income of $738 million for 2014 increased $218 million from 2013. The increase is primarily due to a decline in the operating cost ratio in 2014 on a revenue base that reflects growth from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 329 million in 2014, up 20% versus scripts of approximately 274 million in 2013. The increase primarily reflects growth associated with higher average medical membership for 2014 than in 2013.

Services revenue

- Services revenue for 2014 were relatively unchanged from 2013, increasing $3 million, or 0.2%, to $1.4 billion for 2014.